NO. 11-400

In the Supreme Court of the United States

STATES OF FLORIDA, SOUTH CAROLINA, NEBRASKA, TEXAS, UTAH, LOUISIANA, ALABAMA, COLORADO, PENNSYLVANIA, WASHINGTON, IDAHO, SOUTH DAKOTA, INDIANA, NORTH DAKOTA, MISSISSIPPI, ARIZONA, NEVADA, GEORGIA, ALASKA, OHIO, KANSAS, WYOMING, WISCONSIN, AND MAINE; BILL SCHUETTE, ATTORNEY GENERAL OF MICHIGAN; AND TERRY BRANSTADGOVERNOR OF IOWA,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *ET AL.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

JOINT APPENDIX ON MEDICAID

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January 10, 2012

Petition for Writ of Certiorari filed Sept. 28, 2011
Certiorari Granted Nov. 14, 2011

TABLE OF CONTENTS

The following opinions, decisions, judgments, and order have been omitted in printing this joint appendix because they appear in the following pages in the appendix to the Petition for Certiorari, No. 11-398:

RELEVANT DOCKET ENTRIES

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT
Civil Docket for Case No. 11-11021

STATE OF FLORIDA, *et al.* v. U.S. DEP'T OF HEALTH & HUMAN SERVS., *et al.*

Date Filed	Document
03/09/2011	CIVIL APPEAL DOCKETED. Notice of appeal filed by Appellants Timothy F. Geithner, Kathleen Sebelius, Hilda Solis, United States Department of Health and Human Services, United States Department of Labor and United States Department of the Treasury on 03/08/2011. Appellant brief due 40 days from 03/09/2011. Fee Status: Fee Not Required.
	* * *
03/09/2011	MOTION to expedite filed by Attorney Samantha L. Chaifetz for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury. Opposition to Motion is Unknown [6257236-1]
	* * *

03/10/2011	RESPONSE to Motion to expedite filed by Attorney Samantha L. Chaifetz for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury in 11-11021 filed by Attorney Scott Douglas Makar for Appellees State of Florida, State of Texas, State of South Carolina, State of Nebraska and State of Utah.
03/11/2011	MOTION for initial hearing en banc filed by Attorney Scott Douglas Makar for Appellees State of Florida, State of Texas, State of South Carolina, State of Nebraska and State of Utah. Opposition to Motion is Unknown [6258405-1]

* * *

03/11/2011	ORDER: Motion to expedite filed by Attorney Samantha L. Chaifetz for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury is GRANTED in part: aplt brf due 4/4, cross-aplt 5/4, cross-aple 5/18, reply brf 5/25, No ext., all brfs must be rcvd in

Clerk's office ... Aple's pet for initial hearing remains pndg ... [6257236-2] in 11-11021 JFD [11-11021, 11-11067]

* * *

03/18/2011 Response to Petition for Rehearing filed as to Attorney Samantha L. Chaifetz for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury in 11-11021. [11-11021, 11-11067]

* * *

03/31/2011 ORDER: The Court having been polled at the request of several members of the Court and a majority of the Circuit Judges who are in regular service not having voted in favor of it, (Rule 35, F.R.A.P.), Appellees' Motion for Initial Hearing En Banc is DENIED [6258405-2]. Consistent with the Court's March 11, 2011, order granting in part Appellants' motion to expedite this appeal, this appeal shall also be expedited to oral argument and shall be heard at oral argument on Wednesday, June 8, 2011, at 9:30 A.M. in Atlanta, Georgia before a three judge panel randomly selected. Each side will be given one hour to present oral arguments. Further, consistent

	with Eleventh Cir. I.O.P. 7 (Identity of Panel), following Fed. R. App. 34, the identity of the panel which will hear oral argument will be disclosed no earlier than fourteen days in advance of oral argument. JFD. [11-11021, 11-11067]
	* * *
04/01/2011	E-Brief Tendered: Appellant brief for Appellant United States Department of Health and Human Services, et al. in 11-11021, Cross-Appellee United States Department of Health and Human Services, et al. in 11-11067. [11-11021, 11-11067]
04/04/2011	Appellant's brief filed by United States Department of Health and Human Services in 11-11021. Service date: 04/01/2011 [11-11021] Attorney for Appellee: Cobb - US mail; Attorney for Appellee: Katsas - US mail; Attorney for Appellant: Rivkin - US mail; Attorney for Appellee: Spohn - US mail; Attorney for Appellant: Winship - US mail; [11-11067] Attorney for Appellant: Rivkin - US mail; Attorney for Appellant: Winship - US mail; Attorney for Appellee: Katsas - US mail; Attorney for Appellee: Spohn - US mail. [11-11021, 11-11067]
04/04/2011	Expanded Record Excerpts filed by Attorney Thomas Mark Bondy for

	Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury in 11-11021. Service date: 04/01/2011 US mail - Attorney for Appellant(s): Rivkin, Winship; Attorney for Appellee(s): Cobb, Katsas, Spohn. [11-11021, 11-11067]
	* * *
05/05/2011	E-Brief Tendered: X-Appellant brief for Appellees State of Florida, State of Nebraska, State of South Carolina, State of Texas and State of Utah in 11-11021, Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. [11-11021, 11-11067]

* * *

05/18/2011	Appellant-Cross Appellee's Brief filed by Appellant United States Department of Health and Human Services in 11-11021. Service date: 05/17/2011 US mail - Attorney for Appellees: Clement, Katsas, Rivkin, Spohn, Winship. [11-11021, 11-11067]
05/18/2011	E-Brief Tendered: X-Appellee brief for Appellant United States Department of Health and Human Services in 11-11021. [11-11021, 11-11067]

* * *

05/24/2011	E-Brief Tendered: Reply brief of Appellants/Cross-Appellees brief for Appellants Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. [11-11021, 11-11067]--[Edited 05/25/2011 by EJ]--[Edited 05/25/2011 by EJ]

05/25/2011	Reply Brief filed by Appellants/Cross-Appellees Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah and State of Wisconsin in 11-11067. Service 05/24/2011 US mail - Attorney for Appellees: Carvin, Kaersvang, Katsas, Marshall, Mooppan. [11-11021, 11-11067]

* * *

05/31/2011	Oral argument scheduled. Argument Date: Wednesday, 06/08/2011 Argument Location: Atlanta Courtroom: Atlanta 338. [11-11021, 11-11067]
05/31/2011	ORDER: On its own motion and pursuant to Fed.R.App.P. 2, the Court hereby SUSPENDS Eleventh Circuit Rule 34-4(g) for purposes of these appeals only. Consistent with this Order, the Clerk is directed to provide CD copies of the oral argument to be held in these appeals for purchase.

JFD [11-11021, 11-11067]

06/02/2011	ORDER: In order to remove any potential confusion about our May 31, 2011, Order, we clarify that our Order suspends only that portion of 11th Cir. Rule 34-4(g) which provides that oral argument recordings are for the exclusive use of the Court. Our May 31, 2011, Order does not suspend that portion of the Rule barring recording of oral argument proceedings by anyone other than the Court. As ordered previously, the Clerk of Court is directed to provide CD copies of the oral argument proceedings in these appeals for the purchase. The $26.00 purchase price required by the Court of Appeals Miscellaneous Fee Schedule, 26 U.S.C. 1913, may be paid in cash or by check payable to U.S. Court of Appeals, 11th Circuit ... . JFD, FMH and SM [11-11021, 11-11067]
06/08/2011	Oral argument held. Oral Argument participants were Neal Kumar Katyal for Appellants United States Department of Labor, et al., Michael Anthony Carvin for Appellees National Federation of Independent Business, et al., and Paul D. Clement for Appellees State of Florida and State of Utah, et al. in 11-11021. [11-11021, 11-11067]

06/21/2011	Supplemental Authority filed by Appellees Kaj Ahlburg and Mary Brown in 11-11021, Appellee Mary Brown in 11-11067. Service date: 06/17/2011 US mail - Attorney for Appellants: Bondy, Casey, Clement, Grossman, Jacquot, Kaersvang, Kennedy, Makar, Osterhaus, Rivkin, Winship. [11-11021, 11-11067]
07/07/2011	Supplemental Authority filed by Appellant United States Department of Health and Human Services in 11-11021. Service date: 07/06/2011 email - Attorney for Appellees: Clement, Katsas. [11-11021, 11-11067]
07/13/2011	Response to Supplemental Authority (28J) filed by Appellee Kaj Ahlburg in 11-11021, Appellee Mary Brown in 11-11067. Service date: 07/12/2011 US mail - Attorney for Appellants: Chaifetz, Clement. [11-11021, 11-11067]
08/09/2011	Supplemental Authority filed by Appellant SECRETARY OF THE U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES in 11-11021. Service date: 08/08/2011 US mail - Attorney for Appellees: Clement, Osterhaus, Rivkin. [11-11021, 11-11067]
08/12/2011	Opinion issued by court as to Appellants SECRETARY OF THE U.

	S. DEPARTMENT OF HEALTH & HUMAN SERVICES, Secretary, U.S. Department of Labor, Secretary, US Department of Treasury, U.S. Department of Labor, US Department of Treasury and United States Department of Health and Human Services in 11-11021, Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. Decision: Affirmed in part and Reversed in part. Opinion type: Published. Opinion method: Signed. [11-11021, 11-11067]
08/12/2011	Judgment entered as to Appellant SECRETARY OF THE U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES etc., in 11-11021. [11-11021, 11-11067]

* * *

09/28/2011	Notice of Writ of Certiorari filed as to Appellant United States Department of Health and Human Services. SC# 11-398.
09/28/2011	Notice of Writ of Certiorari filed as to Appellee National Federation of Independent Business. SC# 11-393.
10/03/2011	MOTION to stay mandate filed by Appellee United States Department of Health and Human Services in 11-11067. Motion is Unopposed [6398537-1] [11-11021, 11-11067]

* * *

10/05/2011	ORDER: On Oct. 4, 2011, the parties filed a joint mot to stay the issuance of the mandate ... Accordingly, on or before Noon, Eastern Standard Time on Wednesday, Oct.12, 2011, the parties are directed to jointly submit in writing to the court the reasons why they contend there is good cause for a stay (see file for complete text). JFD [11-11021, 11-11067]
10/11/2011	Response pursuant to court order of 10/05/2011 filed by Dana Kaersvang for U.S. Department of Labor, United States Department of Health and Human Services and US Department of Treasury in 11-11067, SKIP) [11-11021, 11-11067]
10/13/2011	ORDER: Motion to stay mandate filed

	by Appellee United States Department of Health and Human Services is DENIED [6398537-2] JFD, FMH and SM [11-11021, 11-11067]
10/24/2011	Mandate issued as to Appellants Secretary U.S. Department of Health and Human Services, Secretary, U.S. Department of Labor, Secretary, US Department of Treasury, U.S. Department of Labor, US Department of Treasury and United States Department of Health and Human Services in 11-11021, Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. [11-11021, 11-11067]

* * *

RELEVANT DOCKET ENTRIES

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF FLORIDA (Pensacola)

Civil Docket for Case No. 3:10-cv-00091-RV-EMT

STATE OF FLORIDA, *et al.* v. U.S. DEP'T OF HEALTH & HUMAN SERVS., *et al.*

Date Filed	#	Document
03/23/2010	1	COMPLAINT against TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY filed by STATE OF FLORIDA - Filing Fee $350, Receipt Number: 1129-1533627) (WINSHIP, BLAINE) **Modified on 3/23/2010 to correct "docket text" (laj). (Entered: 03/23/2010)
		* * *
3/24/2010	3	Summons Issued as to

		TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY, U.S. Attorney and U.S. Attorney General. (krb) (Entered: 03/24/2010)
3/29/2010	4	NOTICE OF HEARING. Rule 16 Scheduling Conference set for 4/14/2010 09:00 AM in U.S. Courthouse Pensacola before SENIOR JUDGE ROGER VINSON. (lcu) (Entered: 03/29/2010)
		* * *
4/14/2010	24	Minute Entry for proceedings held before SENIOR JUDGE ROGER VINSON: Scheduling Conference held on 4/14/2010. Scheduling Order to be entered. (Court Reporter Donna Boland.) (jrm) (Entered: 04/14/2010)
		* * *
4/14/2010	26	FINAL SCHEDULING ORDER re 24 Scheduling Conference. Plaintiff's date for filing an

		amended complaint: 5/14/10. Defendants' date for filing a motion to dismiss: 6/16/10. Plaintiffs' date for filing a brief in opposition to motion to dismiss: 8/6/10. Defendants' date for filing a reply to Plaintiffs' opposition brief: 8/27/10. Oral argument on Defendants' motion to dismiss: 9/14/10 at 9:00 AM. Discovery deadline: 9/14/10. Signed by SENIOR JUDGE ROGER VINSON on 4/14/10. (tdg) (Entered: 04/14/2010)
4/14/2010	27	Redacted Notice and MOTION for Reconsideration or MOTION (titled Request) for Certification for Interlocutory Appeal – Re: 18 Order. (laj) Modified on 4/23/2010 (jrm). (Entered: 04/15/2010)
		* * *
5/13/2010	41	SUMMONS Returned Executed by STATE OF WASHINGTON, STATE OF ALABAMA, STATE OF SOUTH CAROLINA, STATE OF FLORIDA, STATE OF SOUTH DAKOTA, STATE OF LOUISIANA, STATE OF NEBRASKA, STATE OF COLORADO, STATE OF IDAHO, STATE OF

		MICHIGAN, STATEOF TEXAS, COMMONWEALTH OF PENNSYLVANIA, STATE OF UTAH. TIMOTHY F GEITHNER served on 4/12/2010, answer due 5/3/2010; KATHLEEN SEBELIUS served on 3/29/2010, answer due 4/19/2010; HILDA L SOLIS served on 3/29/2010, answer due 5/3/2010; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES served on 3/29/2010, answer due 5/3/2010; UNITED STATES DEPARTMENT OF LABOR served on 4/2/2010, answer due 5/3/2010; UNITED STATES DEPARTMENT OF THE TREASURY served on 4/12/2010, answer due 5/3/2010. (Attachments: # 1 Exhibit "A" Return of Service of HHS and H. Solis, # 2 Exhibit "B" Return of Service of Treasury and T. Geithner, # 3 Exhibit "C" Return of Service of Labor and H. Solis, # 4 Exhibit "D" return of Service of Attorney General E. Holder) (WINSHIP, BLAINE) (Entered: 05/13/2010)
5/14/2010	42	First AMENDED COMPLAINT by and through Sonny Perdue,

Governor of the State of Georgia, State of Alaska, by and through Daniel S. Sullivan, Attorney General of the State of Alaska, National Federation of Independent Business, a California Nonprofit Mutual Benefit Corporation, State of Nevada, by and through Jim Gibbons, Governor of the State of Nevada, State of North Dakota, by and through Wayne Stenejhem, Attorney General of the State of North Dakota, State of Indiana, by and through Gregory F. Zoeller, Attorney General, State of Mississippi, by and through Haley Barbour, Governor of the State of Mississippi, Kaj Ahlburg, State of Arizona, by and through Janice K. Brewer, Governor of the State of Arizona, Mary Brown, filed by STATE OF WASHINGTON, STATE OF ALABAMA, STATE OF SOUTH CAROLINA, STATE OF FLORIDA, STATE OF SOUTH DAKOTA, STATE OF LOUISIANA, STATE OF NEBRASKA, STATE OF COLORADO, STATE OF IDAHO, STATE OF MICHIGAN, STATE OF

		TEXAS, COMMONWEALTH OF PENNSYLVANIA, STATE OF UTAH (WINSHIP, BLAINE) Modified on 5/14/2010 to clean up text (djb). (Entered: 05/14/2010)

* * *

6/16/2010	55	MOTION to Dismiss by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (Internal deadline for referral to judge if response not filed earlier: 7/6/2010). (Attachments: # 1 Memorandum in Support) (BECKENHAUER, ERIC) (Entered: 06/16/2010)
6/17/2010	56	NOTICE Errata by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES

		DEPARTMENT OF THE TREASURY re 55 MOTION to Dismiss (Attachments: # 1 Memorandum in Support of 55 Defendants' Motion to Dismiss) (BECKENHAUER, ERIC) (Entered: 06/17/2010)
		* * *
8/06/2010	68	RESPONSE in Opposition re 55 MOTION to Dismiss filed by STATE OF FLORIDA, et al (all plaintiffs). (WINSHIP, BLAINE) **Modified on 8/6/2010 to create linkage for filers. (laj). (Entered: 08/06/2010)
		* * *
8/27/2010	74	REPLY to Response to Motion re 55 MOTION to Dismiss filed by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (KENNEDY, BRIAN) (Entered: 08/27/2010)
		* * *

9/15/2010	76	AMENDED FINAL SCHEDULING ORDER – Re: 26 Order – A) I will enter my written Order on the Dfts' 55 Motion to Dismiss on or before 10/14/2010. Assuming the case survives dismissal in whole or in part, the parties have until 11/4/2010 in which to move for summary judgment (and the Dfts may file their answer at the same time); the opposing party will have until 11/23/2010 to respond; and the moving party will have until 12/6/2010 to file any Reply. B) As provided in the original Final Scheduling Order, the briefing with regard to the motions discussed above will be limited to (50) pages for the initial and responsive briefs, and (25) pages for reply briefs. C) Hearing and oral argument on the motion(s) for summary judgment will held on Thursday, 12/16/2010 @ 9:00 AM (CST). Both sides will be allowed (1) hour for argument. Signed by SENIOR JUDGE ROGER VINSON on 9/15/2010. (laj) (Entered: 09/16/2010)

* * *

10/08/2010	78	NOTICE of Supplemental

		Authority by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY (Attachments: # 1 Exhibit Thomas More Law Center v. Obama, No. 10−CV−11156 (E.D. Mich. Oct. 7, 2010)) (BECKENHAUER, ERIC) (Entered: 10/08/2010)
10/14/2010	79	ORDER AND MEMORANDUM OPINION − The Dfts' 55 Motion to Dismiss is GRANTED w/respect to Counts Two, Five, and Six, and those counts are hereby DISMISSED. The Motion is DENIED w/respect to Counts One and Four, Count Three is also DISMISSED, as Moot. The case will continue as to Counts One and Four pursuant to the Scheduling Order previously entered. Signed by SENIOR JUDGE ROGER VINSON on 10/14/2010. (laj) (Entered: 10/14/2010)
11/04/2010	80	MOTION for Summary

		Judgment by PLAINTIFF STATES. (Internal deadline for referral to judge if response not filed earlier: 11/22/2010). (Attachments: # 1 Memorandum of Law, # 2 Statement of Material Facts, # 3 Exhibits Volume I, # 4 Exhibits Volume II, # 5 Exhibits Volume III, # 6 Exhibits Volume IV) (tdg) (Additional attachment(s) added on 11/4/2010: # 7 Exhibits Volume V.1 (35, 36), # 8 Exhibits Volume V.2 (37,38), # 9 Exhibits Volume V.3 (39,40)) (tdg). (Entered: 11/04/2010)
11/04/2010	81	ANSWER to Complaint 42 Amended Complaint by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (BECKENHAUER, ERIC) (Entered: 11/04/2010)
11/04/2010	82	MOTION for Summary Judgment by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS,

		UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (Internal deadline for referral to judge if response not filed earlier: 11/22/2010). (Attachments: # 1 Memorandum in Support, # 2 Statement of Facts) (BECKENHAUER, ERIC) (Entered: 11/04/2010)
11/05/2010	83	NOTICE Errata re Exhibits in support of 82 Defendants' Motion for Summary Judgment by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY (Attachments: # 1 Table of Exhibits, # 2 Exhibit 1, # 3 Exhibit 2, # 4 Exhibit 3, # 5 Exhibit 4, # 6 Exhibit 5, # 7 Exhibit 6, # 8 Exhibit 7, # 9 Exhibit 8, # 10 Exhibit 9, # 11 Exhibit 10, # 12 Exhibit 11, #

		13Exhibit 12, # 14 Exhibit 13, # 15 Exhibit 14, # 16 Exhibit 15, # 17 Exhibit 16, # 18 Exhibit 17, # 19 Exhibit 18, # 20 Exhibit 19, # 21 Exhibit 20, # 22 Exhibit 21, # 23 Exhibit 22, # 24 Exhibit 23, # 25 Exhibit 24, # 26 Exhibit 25, # 27 Exhibit 26, # 28 Exhibit 27, # 29 Exhibit 28, # 30 Exhibit 29, # 31 Exhibit 30, # 32 Exhibit 31, # 33 Exhibit 32, # 34 Exhibit 33, # 35 Exhibit 34, # 36 Exhibit 35, # 37 Exhibit 36, # 38 Exhibit 37, # 39 Exhibit 38, # 40 Exhibit 39, # 41 Exhibit 40, # 42 Exhibit 41, # 43 Exhibit 42, # 44 Exhibit 43) (BECKENHAUER, ERIC) (Entered: 11/05/2010)
11/08/2010	85	NOTICE of Filing by KAJ AHLBURG, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF LOUISIANA, STATE OF MICHIGAN, STATE OF

		MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON (Attachments: # 1 Plaintiffs Statement of Position on Motions for Leave to File Briefs as Amici Curiae) (WINSHIP, BLAINE) (Entered: 11/08/2010)

* * *

11/23/2010	135	PLAINTIFFS MEMORANDUM in Opposition to Defendants' Motion for Summary Judgment 82 filed by STATE OF FLORIDA. (Attachments: # 1 Supplemental Appendix) (tdg) (Entered: 11/23/2010)
11/23/2010	136	PLAINTIFFS' RESPONSE to Defendants' Statement of Facts As to Which There Is No Genuine Issue 82 filed by STATE OF FLORIDA. (tdg) (Entered: 11/23/2010)
11/23/2010	137	MEMORANDUM in Opposition re 80 MOTION for Summary Judgment filed by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS,

		UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (Attachments: # 1 Response to Plaintiffs' Statement of Facts) (BECKENHAUER, ERIC) (Entered: 11/23/2010)
		* * *
12/06/2010	138	REPLY to Response to Motion re 80 MOTION for Summary Judgment filed by KAJ AHLBURG, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OFALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF LOUISIANA, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH

		DAKOTA, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON. (WINSHIP, BLAINE) (Entered: 12/06/2010)
12/06/2010	139	REPLY to Response to Motion re 82 MOTION for Summary Judgment filed by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (BECKENHAUER, ERIC) (Entered: 12/06/2010)

* * *

12/14/2010	143	NOTICE of Supplemental Authority by KAJ AHLBURG, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF

		FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF LOUISIANA, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON (Attachments: # 1 Exhibit Virginia Order Granting Summary Judgment) (WINSHIP, BLAINE) (Entered: 12/14/2010)

* * *

12/16/2010	145	Minute Entry for proceedings held before SENIOR JUDGE ROGER VINSON: oral arguments as to parties' motions for summary judgment held on 12/16/2010. (Court Reporter Donna Boland.) (jmd) (Entered: 12/16/2010)

* * *

1/19/2011	149	ORDER – The plaintiffs' motion for leave to file a second amended complaint (doc. 147) is hereby GRANTED, and the new complaint will be deemed filed

		as of this date, as will the defendants' previously−filed answer. Signed by SENIOR JUDGE ROGER VINSON on 1/19/2011. (djb) (Entered: 01/19/2011)
1/31/2011	150	ORDER GRANTING SUMMARY JUDGMENT − For all the reasons stated and pursuant to Rule 56 of the Federal Rules of Civil Procedure, the plaintiffs motion for summary judgment (doc. 80) is hereby GRANTED as to its request for declaratory relief on Count I of the Second Amended Complaint, and DENIED as to its request for injunctive relief; and the defendants' motion for summary judgment (doc. 82) is hereby GRANTED on Count IV of the Second Amended Complaint. The respective cross−motions are each DENIED. In accordance with Rule 57 of the Federal Rules of Civil Procedure and Title 28, United States Code, Section 2201(a), a Declaratory Judgment shall be entered separately, declaring "The Patient Protection and Affordable Care Act" unconstitutional. Signed by

		SENIOR JUDGE ROGER VINSON on 1/31/2011. (djb) Modified on 1/31/2011 (djb). (Entered: 01/31/2011)
1/31/2011	151	FINAL SUMMARY DECLARATORY JUDGMENT. It is hereby DECLARED, ADJUDGED, and DECREED that The Patient Protection and Affordable Care Act, Pub. L. No. 111−148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111−152, 124 Stat. 1029 (2010), is unconstitutional. Signed by SENIOR JUDGE ROGER VINSON on 1/31/2011. (djb) (Entered: 01/31/2011)
		* * *
2/17/2011	156	MOTION To Clarify re 150 Order on Motion for Summary Judgment, 151 Judgment, by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE

		TREASURY. (BECKENHAUER, ERIC) (Entered: 02/17/2011)
2/18/2011	157	ORDER DIRECTING EXPEDITED FILING re 156 MOTION To Clarify re 150 Order on Motion for Summary Judgment, 151 Judgment. From the date of this Order, the plaintiffs shall have 3 business days in which to file their response in opposition to the defendants' motion. If the defendants wish to file a reply to that response, they shall also have 3 business days from the date the response is filed. (Internal deadline for referral to judge if response not filed on: 2/23/2011.) Signed by SENIOR JUDGE ROGER VINSON on February 18, 2011. (tl) Modified on 2/22/2011 to clarify text. (tl) (Entered: 02/18/2011)
2/23/2011	158	MEMORANDUM in Opposition re 156 MOTION To Clarify re 150 Order on Motion for Summary Judgment, 151 Judgment, filed by KAJ AHLBURG, TERRY E BRANSTAD, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF

		INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF KANSAS, STATE OF LOUISIANA, STATE OF MAINE, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF OHIO, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON, STATE OF WISCONSIN, STATE OF WYOMING. (WINSHIP, BLAINE) Modified on 2/24/2011 to clarify text (tl). (Entered: 02/23/2011)
		* * *
2/28/2011	164	REPLY to 158 Response to 156 MOTION To Clarify re 150 Order on Motion for Summary Judgment, 151 Judgment, filed by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS,

		HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (BECKENHAUER, ERIC) Modified on 3/1/2011 to clarify text, create link. (tl) (Entered: 02/28/2011)
		* * *
3/03/2011	167	ORDER. The defendants' motion to clarify 156 is GRANTED. To the extent that motion is construed as a motion to stay, it is also GRANTED, and the summary declaratory judgment entered in this case is STAYED pending appeal, conditioned upon the defendants filing their notice of appeal within seven (7) calendar days of this order and seeking an expedited appellate review. Signed by SENIOR JUDGE ROGER VINSON on 3/3/11. (tdg) (Entered: 03/03/2011)
		* * *
3/08/2011	169	NOTICE OF APPEAL as to 79 Order on Motion to Dismiss, 150 Order on Motion for Summary

		Judgment, 151 Judgment, 167 Order, by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. ((BECKENHAUER, ERIC) (Entered: 03/08/2011)
		* * *
3/10/2011	173	NOTICE OF CROSS APPEAL as to 79 Order on Motion to Dismiss, 150 Order on Motion for Summary Judgment, 151 Judgment, by KAJ AHLBURG, TERRY E BRANSTAD, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF KANSAS, STATE OF

		LOUISIANA, STATE OF MAINE, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF OHIO, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON, STATE OF WISCONSIN, STATE OF WYOMING. Filing fee $455, receipt number 1129−1831078. Appeal Record due by 3/8/2011. (WINSHIP, BLAINE) (Entered: 03/10/2011)
		* * *
3/11/2011	177	USCA Case Number 11−11021−HH for 169 NOTICE OF APPEAL by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (tl) (Entered: 03/11/2011)

* * *

3/11/2011	179	AMENDED NOTICE OF CROSS APPEAL as to 79 Order on Motion to Dismiss, 150 Order on Motion for Summary Judgment, 151 Judgment, by KAJ AHLBURG, TERRY E BRANSTAD, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF KANSAS, STATE OF LOUISIANA, STATE OF MAINE, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF OHIO, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON, STATE OF WISCONSIN, STATE OF

		WYOMING. Appeal Record due by 3/8/2011. (WINSHIP, BLAINE) Modified on 3/14/2011 to clarify text. (tl) (Entered: 03/11/2011)

* * *

4/04/2011	192	ORDER of USCA as to 169 Notice of Appeal #11−11021−HH, 173 Notice of Cross Appeal #11−11067−HH: Petition for Initial Hearing En Banc is Denied. Motion to expedite this appeal is Granted in part. Oral argument shall be heard on Wednesday, June 8, 2011, at 9:30 A.M. in Atlanta, GA. (tll) (Entered: 04/08/2011)

* * *

10/25/2011	196	MANDATE of USCA AFFIRMING in part and REVERSING in part 169 Notice of Appeal and 173 Notice of Cross Appeal. (USCA Appeal #'s 11-11021-HH; 11-11067-HH) (kvg) (Entered: 10/25/2011)

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 01/18/11
DOCUMENT NO.: 148

SECOND AMENDED COMPLAINT

Pursuant to Rule 15(a), Federal Rules of Civil Procedure, Plaintiffs file this Second Amended Complaint against Defendants and state:

NATURE OF THE ACTION

1. This is an action seeking declaratory and injunctive relief from the "Patient Protection and Affordable Care Act," P.L. 111-148, as amended by the "Health Care and Education Reconciliation Act of 2010," P.L. 111-152 (collectively the Act). The Act's mandate that all citizens and legal residents of the United States maintain qualifying healthcare coverage or pay a penalty (individual mandate) is an unprecedented encroachment on the sovereignty of

the Plaintiff States and on the rights of their citizens, including members of Plaintiff National Federation of Independent Business (NFIB) and individual Plaintiffs Mary Brown and Kaj Ahlburg. By imposing such a mandate, the Act: exceeds the powers of the United States under Article I of the Constitution, particularly the Commerce Clause; violates the Ninth and Tenth Amendments and the Constitution's principles of federalism and dual sovereignty; and violates the Fifth Amendment's Due Process Clause. In the alternative, if the penalty required under the Act is a tax, it constitutes an unlawful capitation or direct tax in violation of Article I, sections 2 and 9 of the Constitution.

2. The Act further violates the Constitution by forcing the Plaintiff States to operate a wholly refashioned Medicaid program. The Act converts Medicaid from a federal-State partnership to provide a safety net for the needy into a federally-imposed universal healthcare regime, in which the discretion of the Plaintiff States has been removed and new requirements and expenses forced upon them in derogation of their sovereignty. In so doing, the Act violates the Ninth and Tenth Amendments and the Constitution's principles of federalism.

3. Plaintiffs seek declaratory and injunctive relief against the Act's operation in order to avoid an unprecedented and unconstitutional intrusion by the federal government into the private affairs of every American and to preserve Plaintiff States' respective sovereignty, as guaranteed by the Constitution.

JURISDICTION AND VENUE

4. The Court has subject-matter jurisdiction pursuant to 28 U.S.C. § 1331 because this action arises under the Constitution and laws of the United States and further has jurisdiction to render declaratory relief under 28 U.S.C. § 2201.

5. Venue is proper in this district pursuant to 28 U.S.C. § 1391(e)(3) because no real property is involved, the district is situated in Florida, and the defendants are agencies of the United States or officers thereof acting in their official capacity.

PARTIES

6. The State of Florida, by and through Pam Bondi, Attorney General of Florida, is a sovereign State in the United States of America.

7. The State of South Carolina, by and through Alan Wilson, Attorney General of South Carolina, is a sovereign State in the United States of America.

8. The State of Nebraska, by and through Jon Bruning, Attorney General of Nebraska, is a sovereign State in the United States of America.

9. The State of Texas, by and through Greg Abbott, Attorney General of Texas, is a sovereign State in the United States of America.

10. The State of Utah, by and through Mark L. Shurtleff, Attorney General of Utah, is a sovereign State in the United States of America.

11. The State of Alabama, by and through Luther Strange, Attorney General of Alabama, is a sovereign State in the United States of America.

12. The State of Louisiana, by and through James D. "Buddy" Caldwell, Attorney General of Louisiana, is a sovereign State in the United States of America.

13. Bill Schuette, Attorney General of Michigan, is bringing this action on behalf of the People of Michigan under Mich. Comp. Law § 14.28, which provides that the Michigan Attorney General may "appear for the people of [Michigan] in any other court or tribunal, in any cause or matter, civil or criminal, in which the people of [Michigan] may be a party or interested." Under Michigan's constitution, the people are sovereign. Mich. Const. art. I, § 1 ("All political power is inherent in the people. Government is instituted for their equal benefit, security, and protection.").

14. The State of Colorado, by and through John W. Suthers, Attorney General of Colorado, is a sovereign State in the United States of America.

15. The Commonwealth of Pennsylvania, by and through Thomas W. Corbett, Jr., Governor of Pennsylvania, and William H. Ryan, Jr., Acting Attorney General of Pennsylvania, is a sovereign State in the United States of America.

16. The State of Washington, by and through Robert A. McKenna, Attorney General of Washington, is a sovereign State in the United States of America.

17. The State of Idaho, by and through Lawrence G. Wasden, Attorney General of Idaho, is a sovereign State in the United States of America.

18. The State of South Dakota, by and through Marty J. Jackley, Attorney General of South Dakota, is a sovereign State in the United States of America.

19. The State of Indiana, by and through Gregory F. Zoeller, Attorney General of Indiana, is a sovereign State in the United States of America.

20. The State of North Dakota, by and through Wayne Stenehjem, Attorney General of North Dakota, is a sovereign State in the United States of America.

21. The State of Mississippi, by and through Haley Barbour, Governor of Mississippi, is a sovereign State in the United States of America.

22. The State of Arizona, by and through Janice K. Brewer, Governor of Arizona, and Thomas C. Horne, Attorney General of the State of Arizona, is a sovereign State in the United States of America.

23. The State of Nevada, by and through Jim Gibbons, Governor of Nevada, is a sovereign State in the United States of America.

24. The State of Georgia, by and through Samuel S. Olens, Attorney General of Georgia, is a sovereign State in the United States of America.

25. The State of Alaska, by and through Daniel S. Sullivan, Attorney General of Alaska, is a sovereign State in the United States of America.

25A. The State of Ohio, by and through Michael DeWine, Attorney General of Ohio, is a sovereign State in the United States of America.

25B. The State of Kansas, by and through Derek Schmidt, Attorney General of Kansas, is a sovereign State in the United States of America.

25C. The State of Wyoming, by and through Matthew H. Mead, Governor of Wyoming, is a sovereign State in the United States of America.

25D. The State of Wisconsin, by and through J.B. Van Hollen, Attorney General of Wisconsin, is a sovereign State in the United States of America.

25E. The State of Maine, by and through William J. Schneider, Attorney General of Maine, is a sovereign State in the United States of America.

25F. Terry E. Branstad, Governor of Iowa, is bringing this action on behalf of the People of Iowa, a sovereign State in the United States of America.

26. The National Federation of Independent Business (NFIB), a California nonprofit mutual benefit corporation, is the nation's leading association of small businesses, including individual members, and has a presence in all 50 States and the District of Columbia. NFIB's mission is to promote and protect the rights of its members to own, operate, and earn success in their businesses, in accordance with lawfully imposed governmental requirements. The NFIB Small Business Legal Center is a nonprofit, public interest law firm established to provide legal resources and be the voice for small businesses in the nation's courts through representation on issues of public interest affecting small businesses. NFIB's members include individuals who object to: forced compliance with the Act's mandate that they obtain qualifying healthcare

insurance or pay a penalty; diversion of resources from their businesses that will result from complying with the mandate; and the Act's overreaching and unconstitutional encroachment on the States' sovereignty. NFIB joins in those objections on behalf of its members. NFIB's services to its members include providing information regarding legal and regulatory issues faced by small businesses, including individuals. NFIB will incur additional costs in assisting its members in understanding how the Act applies to them and affects their businesses.

27. Mary Brown is a citizen and resident of the State of Florida and a citizen of the United States. She is self-employed, operating Brown & Dockery, Inc., an automobile repair facility in Panama City, Florida, and is a member of NFIB. Ms. Brown has not had healthcare insurance for the last four years, and devotes her resources to maintaining her business and paying her employees. She does not qualify for Medicaid under the Act or Medicare and does not expect to qualify for them prior to the Act's individual mandate taking effect. Ms. Brown will be subject to the mandate and objects to being forced to comply with it, and objects to the Act's unconstitutional overreaching and its encroachment on the States' sovereignty.

28. Kaj Ahlburg is a citizen and resident of the State of Washington and a citizen of the United States. Mr. Ahlburg has not had healthcare insurance for more than six years, does not have healthcare insurance now, and has no intention or desire to have healthcare insurance in the future. Mr. Ahlburg is and reasonably expects to remain financially able to pay for his own healthcare

services if and as needed. He does not qualify for Medicaid under the Act or Medicare and does not expect to qualify for them prior to the Act's individual mandate taking effect. Mr. Ahlburg will be subject to the mandate and objects to being forced to comply with it, and objects to the Act's unconstitutional overreaching and its encroachment on the States' sovereignty. (Plaintiffs Brown and Ahlburg are referred to as the Individual Plaintiffs.)

29. The Department of Health and Human Services (HHS) is an agency of the United States, and is responsible for administration and enforcement of the Act, through its center for Medicare and Medicaid Services.

30. Kathleen Sebelius is Secretary of HHS, and is named as a party in her official capacity.

31. The Department of the Treasury (Treasury) is an agency of the United States, and is responsible for administration and enforcement of the Act.

32. Timothy F. Geithner is Secretary of the Treasury, and is named as a party in his official capacity.

33. The Department of Labor (DOL) is an agency of the United States, and is responsible for administration and enforcement of the Act.

34. Hilda L. Solis is Secretary of DOL, and is named as a party in her official capacity.

FACTUAL ALLEGATIONS

The Unprecedented and Unconstitutional Individual Mandate

35. The Act mandates that all persons who are citizens or legal residents of any State within the United States, including NFIB members and the Individual Plaintiffs, must have and maintain qualifying healthcare coverage, regardless of whether they wish to do so, to avoid having to pay a penalty. Many individuals, including NFIB members and the Individual Plaintiffs, will be forced to purchase the required coverage with their own assets, without contribution or subsidy from the federal government. If a person fails to maintain such coverage, the federal government will force that person to pay a penalty, the amount of which will be increased gradually through 2016, reaching 2.5 percent of household income or $695 per year (up to a maximum of three times that amount ($2,085)) per family, whichever is greater. After 2016, the penalty will increase annually based on a cost-of-living adjustment.

36. Exemptions to the penalty apply for individuals with certain religious objections, individuals who belong to certain faith-based healthcare cooperative organizations, American Indians, persons without coverage for less than three months, undocumented immigrants, incarcerated individuals, persons for whom the lowest cost plan option exceeds 8 percent of income, individuals with incomes below the tax filing threshold, and persons with financial hardships. Millions of individuals will

be forced to choose between having qualified coverage and paying the penalty.

37. Congress never before has imposed a mandate that all citizens buy something—in this case health insurance—or pay a penalty. According to the non-partisan Congressional Budget Office (CBO), "the imposition of an individual mandate [to buy health insurance] . . . would be unprecedented. The government has never required people to buy any good or service as a condition of lawful residence in the United States." THE BUDGETARY TREATMENT OF AN INDIVIDUAL MANDATE TO BUY HEALTH INSURANCE, CBO MEMORANDUM (August 1994), http://www.cbo.gov/ftpdocs/48xx/doc4816/doc38.pdf (last visited May 11, 2010). The CBO added that an individual mandate could "transform the purchase of health insurance from an essentially voluntary private transaction into a compulsory activity mandated by law." *Id.*

38. Congress lacks the constitutional authority to enact the individual mandate. The Constitution limits Congress's authority to the specific powers enumerated in Article I, and thus does not grant unlimited authority to Congress. None of Congress's enumerated powers includes the authority to force every American to buy a good or service on the private market or face a penalty. For the first time, Congress under the Act is attempting to regulate and penalize Americans for choosing not to engage in economic activity. If Congress can do this much, there will be virtually no sphere of private decision-making beyond the reach of federal power.

Medicaid Program Prior to the Act

39. Medicaid was established by Title XIX of the Social Security Act of 1965, 42 U.S.C. §§ 1396 *et seq.*, as the nation's major healthcare program for low-income persons. The States and the federal government have funded each participating State's Medicaid program jointly.

40. From the beginning of Medicaid until passage of the Act, the States were given considerable discretion to implement and operate their respective Medicaid programs in accordance with State-specific designs regarding eligibility, enrollment, and administration, so long as the programs met broad federal requirements.

41. At the outset of Medicaid, the States were free to opt in and establish their own State health or welfare plans or to provide no benefits at all. None of the Plaintiff States agreed to become a Medicaid partner of the federal government with an expectation that: a) the terms of its participation would be altered significantly; b) the federal government would increase significantly its own control and reduce significantly that State's discretion over the Medicaid program; c) the federal government would alter the program's requirements to expand eligibility for enrollment beyond the State's ability to fund its participation; d) the federal government would alter the program from requiring that States pay for healthcare services to requiring that States provide such services; or e) the federal government would exercise its control over Medicaid terms and eligibility as part of a coercive scheme to

force all citizens and residents of the States to have healthcare coverage.

The Act's Injurious Impact on the Federal-State Healthcare Partnership

42. The Act greatly alters the federal-State relationship, to the detriment of the Plaintiff States, with respect to Medicaid programs, their insurance regulatory role, and healthcare coverage generally.

43. The Act transforms Medicaid from federal-State partnerships into a broad federally-controlled program that deprives the States of the ability to define healthcare program eligibility and attributes, and eliminates States' historic flexibility to make costsaving and other adjustments to their respective Medicaid programs. The Act also sets new increased Medicaid rates for primary-care practitioners' reimbursements, which States must substantially fund, and changes the manner in which drug rebates are allocated between the federal government and States in a manner that financially benefits the federal government at the States' expense.

44. The Act requires each State to expand massively its Medicaid program and to create a statewide exchange, which must be either a State governmental agency or a nonprofit entity established by the State for this purpose, through which the citizens and residents of that State can purchase healthcare insurance. If a State does not satisfy federal requirements to progress toward creation of an intrastate insurance exchange between now and the end of 2012, or chooses not to operate an exchange, the federal government (or its contractor) will establish and administer an

intrastate exchange within that State. This action would displace State authority over a substantial segment of intrastate insurance regulation (e.g., licensing and regulation of intrastate insurers, plans, quality ratings, coordination with Medicaid and other State programs, and marketing) that the States have always possessed under the police powers provided in the Constitution, and subject the States to possible exchange-related penalties.

45. Participation in the Act will force the States to expand their Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level. The federal government will fund much of the cost initially, but States' coverage burdens will increase significantly after 2016, both in actual dollars and in proportion to the contributions of the federal government.

46. The Act further requires that States provide healthcare services to enrollees, a significant new obligation that goes far beyond the States' pre-Act responsibility for funding healthcare services under their respective Medicaid programs. This obligation will expose the States to significant increased litigation risks and costs.

47. The federal government will not provide full funding or resources to the States to administer the Act. Each State must oversee the newly-created intrastate insurance market by instituting regulations, consumer protections, rate reviews, solvency and reserve fund requirements, and premium taxes. Each State also must enroll all of the newly-eligible Medicaid beneficiaries (many of whom will be subject to a penalty if they fail to

enroll), coordinate enrollment with the new intrastate insurance exchange, and implement other specified changes. The Act further requires each State to establish a reinsurance program by 2014, to administer a premium review process, and to cover costs associated with State-mandated insurance benefit requirements that States previously could impose without assuming a cost.

48. In addition, the Act imposes new requirements on the Plaintiff States that interfere with their ability to perform governmental functions. Effective in 2014, the Plaintiff States, as large employers, must automatically enroll employees working 30 or more hours a week into health insurance plans, without regard for current State practice, policy preferences, or financial constraints. The Act's individual mandate effectively will force many more State employees into State insurance plans than the Plaintiff States now allow, at a significant added cost to the States. Moreover, the States will be subject to substantial penalties and taxes prescribed by the Act, at a cost of thousands of dollars per employee, for State employees who obtain subsidized insurance from an exchange instead of from a State plan, or if the State plan offers coverage that is either too little or too generous as determined by the federal government. New tax reporting requirements prescribed by the Act also will burden the Plaintiff States' ability to source goods and services as necessary to carry out governmental functions.

The Act's Injurious Impact on Plaintiffs

49. The Act will have a profound and injurious impact on all Plaintiff States. Florida's circumstances, as described below, are not identical to the circumstances in all of the Plaintiff States, but fairly represent the nature of the burdens the Act imposes on the Plaintiff States.

50. Based on United States Census Bureau statistics from 2008, Florida has 3,641,933 uninsured persons living in the State. Of those persons, 1,259,378 are below 133 percent of the federal poverty line; therefore, the Act requires that Florida add them to its Medicaid rolls.

51. Even before passage of the Act, the Medicaid program imposed a heavy cost on Florida, consuming 26 percent of its annual budget. For fiscal year 2009-2010 alone, Florida will spend more than $18 billion on Medicaid, servicing more than 2.7 million persons. Florida's Medicaid contributions and burdens, from the implementation of its Medicaid program in 1970 to the present, have gradually increased to the point where it would be infeasible for Florida to cease its participation in Medicaid before the Act takes effect and make alternate arrangements for a traditional Medicaid-like program.

52. The federal government currently contributes 67.64 percent of every dollar Florida spends on Medicaid, a percentage that is temporarily inflated because of federal stimulus outlays. Under the current pre-Act program, after this year, the percentage of Florida's Medicaid expenses covered by the federal government would decline, and by 2011

would reach 55.45 percent, a level that is closer to the recent average. The federal government's contribution under the Act, though providing more aid for newly-eligible persons, will not fully compensate Florida for the dramatic increase to its Medicaid rolls, increased reimbursement rates for primary-care practitioners, and other substantial costs that it must bear under the Act.

53. Florida's Agency for Health Care Administration (AHCA) estimates that at least 80 percent of persons who have some form of health insurance but fall below 133 percent of the federal poverty level will drop their current plans and enroll in Medicaid, because they are newly eligible under the Act. The Act does not provide full funding for the States' cost of covering these already-covered persons. These persons represent a significant additional cost to Florida under the Act.

54. The Act also makes a large new class of persons eligible for Medicaid in Florida. Prior to passage of the Act, only certain specified low-income individuals and families qualified for Medicaid. Moreover, the qualifying income level set by Florida was generally much lower than the level of 133 percent of the federal poverty line set by the federal government under the Act. Now, Florida also must add to its Medicaid rolls every childless adult whose income falls below 133 percent of the federal poverty line, consistent with the Act's fundamental change in Medicaid from a federal-State partnership to provide a safety net for the needy into a federally-imposed regime for universal healthcare coverage.

55. Prior to passage of the Act, AHCA was Florida's designated State Medicaid agency tasked with developing and carrying out policies related to the Medicaid program. The Act will strip away much of the State's authority to establish and execute policies, transferring that authority to the federal government. Indeed, the Act renders AHCA and other Florida agencies mere arms of the federal government and commandeers and forces AHCA employees to administer what now is essentially a federal universal healthcare program.

56. AHCA projects a cost to Florida in the billions of dollars between now and 2019, stemming from Medicaid-related portions of the Act. The annual cost will continue to grow in succeeding years. AHCA's projections, moreover, understate the Act's adverse impact on Florida. They do not include estimated costs to be borne by Florida to administer the Act or to prepare for the Act's implementation. Such costs will include hiring and training new staff, creating new information technology infrastructures, developing an adequate provider base, creating a scheme for accountability and quality assurance, and incurring many other expenses.

57. The Act requires that Florida immediately begin to devote funds and other resources to implement sweeping changes across multiple agencies of government. Such implementation burdens include, but are not limited to: a) enforcing the Act's immediately-effective terms; b) determining gaps between current resources in State government and the Act's requirements; c) evaluating infrastructure to consider how new programs and substantial expansion of existing

programs will be implemented (e.g., new agencies, offices, etc.); d) developing a strategic plan and coordinating common issues across State agencies; e) initiating legislative and regulatory processes, while at the same time monitoring and engaging the substantial federal regulatory processes to ensure that State interests are protected; f) electing whether to participate in optional programs set forth in the Act; g) satisfying the Act's interim targets; and h) developing communications structure and plan to disseminate new information regarding changes brought about by the Act to the many affected persons and entities.

58. The Act further requires Florida to enroll in healthcare insurance plans categories of State employees not previously covered by State-funded healthcare insurance plans. The Act subjects the State to penalties, depending upon the coverage decisions made by its employees, and limits the State's ability to determine coverage. If the State's plan for its employees is deemed inadequate by the federal government, the State will be subject to penalties. If the State's plan is deemed too generous or expansive by the federal government, the State will be subject to a distinct federal tax liability.

59. The Act also requires that Florida be responsible for providing healthcare services for all Medicaid enrollees in the expanded program, a significant change from Florida's responsibility for providing payment for such services. This added responsibility and resulting new legal liabilities further contribute to the Act's substantial and costly impact on Florida's fisc, and will force the State to

ignore other critical needs, including education, corrections, law enforcement, and more.

60. In sum, as demonstrated through the effects on Florida, the Act infringes on the Plaintiff States' constitutional status as sovereigns, entitled to cooperate with but not to be controlled by the federal government under the Medicaid program.

61. In addition, the Act will have a profound and injurious impact on the Plaintiff States' citizens and residents, a significant number of whom are or will be subject to the Act's mandate to obtain qualifying healthcare coverage or pay a penalty.

62. The Act further will have a profound and injurious impact on NFIB's individual members and its uninsured small business owners, including Ms. Brown, who are and will continue to be subject to the Act's mandate to obtain qualifying healthcare coverage or pay a penalty. Because of the mandate, these members will be forced to divert resources from their business endeavors, or otherwise to reorder their economic circumstances, in order to obtain qualifying healthcare coverage, regardless of their own conclusions on whether or not obtaining and maintaining such coverage for themselves and their dependents is a worthwhile cost of doing business. The added costs of the mandate will threaten the members' ability to maintain their own, independent businesses.

63. An important service offered by NFIB to its membership is the provision of information and assistance regarding legal and regulatory compliance issues faced by small businesses, as well as questions involving healthcare insurance and

benefits. In order fully to serve the needs and interests of its membership, NFIB now will be forced to devote its own scarce resources to assisting members in understanding how the Act, including the mandate to obtain qualifying coverage or pay a penalty, applies to them, how it will affect their businesses, and what they must do to comply.

64. The Act also will injure Mr. Ahlburg, who will be subject to the Act's mandate to obtain qualifying healthcare coverage or pay a penalty. The Act's Requirements and Effects on the Plaintiff States Cannot Be Avoided

65. Plaintiff States cannot avoid the Act's requirements. Neither the Act nor current federal Medicaid provisions prescribe a mechanism for a State to opt out of the Act's new Medicaid requirements, to opt out of Medicaid generally, or to transition to another program that provides only traditional Medicaid services.

66. Moreover, if they were to end their longstanding participation in Medicaid, Plaintiff States would desert millions of their residents, leaving them without access to the healthcare services they have depended on for decades under Medicaid. Thus, Plaintiff States are forced to accept the harmful effects of the Act on their fiscs and their sovereignty.

67. Prior to passage of the Act, Medicaid and its corresponding law, regulations, guidance, policies, and framework had been well-established, subject to occasional limited modifications, for more than four decades. During that time, participating States developed their respective Medicaid programs in

reliance on Medicaid continuing to be a partnership with the federal government.

68. Presently, the Centers for Medicare and Medicaid (CMS), the federal agency with chief responsibility for administering Medicaid for the federal government, will terminate a State's federal funding for Medicaid unless the State complies with the Act's requirements. In addition, Medicaid requirements are linked to other federal programs, and the benefits of those programs to a State and its citizens and residents would be in jeopardy if the federal government were to terminate the State's participation in Medicaid.

CAUSES OF ACTION

COUNT ONE

UNCONSTITUTIONAL MANDATE THAT ALL INDIVIDUALS HAVE HEALTHCARE INSURANCE COVERAGE OR PAY A PENALTY

(Const. art. I & amend. IX, X)

69. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

70. The Act forces all Americans, including NFIB members and the Individual Plaintiffs, regardless of whether they want healthcare coverage, to obtain and maintain a federally-approved level of coverage or pay a penalty. The Act thus compels all Americans to perform an affirmative act or incur a penalty, simply on the basis that they exist and reside within any of the United States. In so doing, the Act purports to exercise the very type of general police power the

Constitution reserves to the States and denies to the federal government.

71. The Act is directed to a lack of, or failure to engage in, activity that is driven by the choices of individual Americans. Such inactivity by its nature cannot be deemed to be in commerce or to have such an effect on commerce, whether interstate or otherwise, as to be subject to Congress's powers under the Commerce Clause, Const. art. I, § 8. Nor does the Act regulate (directly or indirectly) any properly regulable interstate or foreign market or other commerce, any instrumentality of interstate or foreign commerce, or the actual flow of goods, services, and human beings among the States. As a result, the Act cannot be upheld under the Commerce Clause.

72. The Act infringes upon Plaintiff States' sovereign interests by coercing many persons to enroll in an expanded Medicaid program at a substantial cost to Plaintiff States, or to obtain coverage from intrastate exchanges that States must establish to avoid loss of substantial regulatory authority. The Act also denies Plaintiff States their sovereign ability to confer rights upon their citizens and residents to make healthcare decisions without government interference, including the decision not to participate in any healthcare insurance program or scheme, in violation of the Ninth and Tenth Amendments to the Constitution and the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

73. The Act's penalty on uninsured persons unlawfully coerces persons to obtain healthcare

coverage without purposing to raise revenue and injures the Plaintiff States' fiscs, because many persons will be compelled to enroll in Medicaid at a substantial cost to Plaintiff States or to get coverage from intrastate exchanges that Plaintiff States must establish to avoid loss of substantial regulatory authority. As a result, the Act cannot be upheld under the Taxing and Spending Clause, Const. art. I, § 8.

74. By requiring and coercing citizens and residents of the Plaintiff States to have healthcare coverage, the Act exceeds Congress's limited powers enumerated in Article I of the Constitution, and cannot be upheld under any other provision of the Constitution.

75. By requiring and coercing citizens and residents of the Plaintiff States to have healthcare coverage, the Act deprives those citizens and residents, and NFIB members and the Individual Plaintiffs, of their rights under State law to make personal healthcare decisions without governmental interference, and violates the rights of the States as sovereigns to confer and define such rights in their constitutions or by statute, in violation of the Ninth and Tenth Amendments to the Constitution and the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare that the individual mandate exceeds Congress's authority under Article I of the Constitution and violates the Ninth and Tenth Amendments;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, including their agencies, officials, and employees; the citizens and residents of the Plaintiff States; NFIB members and small business owners; and the Individual Plaintiffs, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiffs their costs and grant such other relief as the Court may deem just and proper.

COUNT TWO

UNCONSTITUTIONAL MANDATE THAT ALL INDIVIDUALS HAVE HEALTHCARE INSURANCE COVERAGE OR PAY A PENALTY

(Const. amend. V)

76. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

77. The Act forces citizens and residents of the Plaintiff States, including NFIB members and the Individual Plaintiffs, to obtain and maintain a federally-approved level of health coverage for themselves and their dependents, regardless of whether they want or need that coverage, or pay a penalty.

78. By requiring and coercing NFIB's members and the Individual Plaintiffs to obtain and maintain such healthcare coverage, the Act deprives them of their right to be free of unwarranted and unlawful federal government compulsion in violation of the Due Process Clause of the Fifth Amendment to the Constitution of the United States.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare Defendants to have violated the rights of NFIB members and small business owners and the Individual Plaintiffs under the Due Process Clause of the Fifth Amendment;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against NFIB members and small business owners and the Individual Plaintiffs, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award NFIB and the Individual Plaintiffs their costs and grant such other relief as the Court may deem just and proper.

COUNT THREE

VIOLATION OF CONSTITUTIONAL PROHIBITION OF UNAPPORTIONED CAPITATION OR DIRECT TAX

(Const. art. I, §§ 2, 9 & amends. IX, X)

79. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

80. Alternatively, the penalty on uninsured persons under the Act constitutes a capitation and a direct tax that is not apportioned among the States according to census data, thereby injuring the sovereign interests of Plaintiff States and the interests of all citizens and residents of the Plaintiff States and of the United States.

81. The tax applies without regard to property, profession, or any other circumstance, and is unrelated to any taxable event or activity. It is to be levied upon persons for their failure or refusal to do anything other than to exist and reside in any of the States comprising the United States.

82. The tax violates article I, sections 2 and 9 of, and the Ninth and Tenth Amendments to, the Constitution. The Act's imposition of the tax, and the resulting coercion of many persons either to enroll in an expanded Medicaid program at a substantial cost to the Plaintiff States or to get coverage from intrastate exchanges that States must establish to avoid loss of substantial regulatory authority, injures Plaintiff States' sovereign interests and violates the States' constitutional protection against unapportioned capitation taxes or direct taxation.

The tax also infringes on the right of NFIB members and the Individual Plaintiffs to be free from unconstitutional taxation. The tax is unconstitutional on its face and cannot be applied constitutionally.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare Defendants to have violated the Plaintiff States' constitutional protection against unapportioned capitation taxes or direct taxation, and to have violate the rights of all citizens and residents of the Plaintiff States and of the United States, including NFIB members and small business owners and the Individual Plaintiffs, to be free from unconstitutional taxation;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, including their agencies, officials, and employees; the citizens and residents of the Plaintiff States; NFIB members and small business owners; and the Individual Plaintiffs, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiffs their costs and grant such other relief as the Court may deem just and proper.

COUNT FOUR

COERCION AND COMMANDEERING AS TO MEDICAID

(Const. art. I & amends. IX, X)

83. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

84. Plaintiff States cannot afford the unfunded costs of participating under the Act, but effectively have no choice other than to participate.

85. The Act exceeds Congress's powers under Article I of the Constitution, and cannot be upheld under the Commerce Clause, Const. art. I, §8; the Taxing and Spending Clause, *id.*; or any other provision of the Constitution.

86. By using Medicaid to reach universal healthcare coverage goals and forcing fundamental changes in the nature and scope of the Medicaid program upon the Plaintiff States, by denying Plaintiff States any choice with respect to new Medicaid requirements and denying them flexibility to limit the fiscal impact of those changes, by effectively co-opting Plaintiff States' control over their budgetary processes and legislative agendas through compelling them to assume costs they cannot afford, by forcing Plaintiff States to become responsible for providing healthcare services for all Medicaid enrollees, by requiring Plaintiff States to carry out insurance mandates and establish intrastate insurance programs and regulations for federal purposes, by interfering in the Plaintiff States' relationships with their employees with

respect to healthcare coverage, by commandeering the Plaintiff States and their employees as agents of the federal government's regulatory scheme at the States' own cost, and by interfering in the Plaintiff States' sovereignty, the Act violates Article IV, section 4 of the Constitution, depriving Plaintiff States of their sovereignty and their right to a republican form of government; violates the Ninth and Tenth Amendments; and violates the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

WHEREFORE, Plaintiff States respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare that the Act exceeds Congress' powers under Article I of the Constitution and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and constitutional principles of federalism and dual sovereignty;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, their citizens and residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiff States their costs and grant such other relief as the Court may deem just and proper.

COUNT FIVE

COERCION AND COMMANDEERING AS TO HEALTHCARE INSURANCE

(Const. art. I & amends. IX, X)

87. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

88. By requiring the Plaintiff States to carry out insurance mandates and establish intrastate insurance programs for federal purposes under threat of removing or significantly curtailing their long-held regulatory authority as to intrastate insurance, and by commandeering the Plaintiff States and their employees as agents of the federal government's regulatory scheme at the States' own cost, the Act exceeds Congress's powers under Article I of the Constitution, and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

WHEREFORE, Plaintiff States respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare that the Act exceeds Congress' powers under Article I of the Constitution and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and constitutional principles of federalism and dual sovereignty;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, their citizens and residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiff States their costs and grant such other relief as the Court may deem just and proper.

COUNT SIX

INTERFERENCE WITH THE STATES' SOVEREIGNTY AS EMPLOYERS AND PERFORMANCE OF GOVERNMENTAL FUNCTIONS

(Const. art. I & amends. IX, X)

89. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

90. By imposing new employer healthcare insurance mandates on the Plaintiff States, by requiring that they automatically enroll and continue enrollment of employees in healthcare plans, by subjecting States to penalties and taxes depending upon plan attributes and individual employee coverage decisions, and by burdening the States' ability to procure goods and services and to carry out governmental functions, the Act exceeds Congress's powers under Article I of the Constitution, and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth

Amendments and the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

WHEREFORE, Plaintiff States respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare that the Act exceeds Congress's powers under Article I of the Constitution, and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and constitutional principles of federalism and dual sovereignty;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, their citizens and residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiff States their costs and grant such other relief as the Court may deem just and proper.

Respectfully submitted,

PAMELA JO BONDI
ATTORNEY GENERAL OF FLORIDA

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF ELIZABETH DUDEK

Pursuant to 28 U.S.C. § 1746, I, Elizabeth Dudek, declare the following:

1. My name is Elizabeth Dudek. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Florida Agency for Health Care Administration (AHCA) as the Interim Secretary.

2. I have served as Interim Secretary since September 2010.

3. As the Interim Secretary, I am the highest ranking official in AHCA and am responsible for

all activities of the Agency including the operation of the Medicaid program.

4. Providing this declaration is within the scope of my authority and the facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration. The facts and projections contained in this declaration regarding the impact of PPACA, however, were not originally prepared in anticipation of this or any other litigation. AHCA originally compiled the facts and projections contained herein as part of its responsibility to report to Florida's elected officials on developments that will impact the Medicaid program. AHCA has prepared and maintained those projections in the regular course of its state business.

A. Florida's Medicaid Program

5. Florida participates in the Medicaid program, and has participated continuously in the program for more than 40 years. The Federal Medicaid law requires states to designate a "single state agency" responsible for the implementation of the state's Medicaid program. 42 U.S.C. § 1396a(a)(5). [The federal law does, however, allow states under certain circumstances to bifurcate their Medicaid programs so that one agency makes eligibility determinations, while another agency serves as the "single state agency" for those found eligible. *Id.* Florida has done just that, with the Florida Department of Children and Families (DCF) conducting eligibility determinations and AHCA

administering the program for those found eligible. As Florida's eligibility agency, DCF may also be impacted by PPACA.]

6. As Florida's single state agency, AHCA cannot and does not delegate, to anyone other than its own officials, the authority to issue policies, rules, and regulations on Medicaid program matters. 42 C.F.R. § 431.10(e)(1)(ii). No other state agency or entity has the authority to change or disapprove of any of AHCA's administrative decisions, and no other state agency or entity can substitute its judgment for AHCA's with respect to the application of policies, rules, and regulations that AHCA has issued. 42 C.F.R. § 431.10(e)(3). *Id.*

7. As of fiscal year 2008-09, Florida's total Medicaid program budget (including federal and state dollars) consumed 24.16% percent of the State's total annual budget. This percentage has steadily increased over the years. In fiscal year 1991-1992, for example, the total Medicaid program budget consumed 13.10% of the total state budget.

8. For the current fiscal year, AHCA estimates that it will spend $20.2 billion dollars on the Medicaid program, which will exceed 28% of the state's total budget. AHCA anticipates that the program will serve over 2.9 million eligible recipients per month during this fiscal year.

B. Impact of PPACA

Medicaid Eligibility Expansion and Increased Rates for Primary Care Practitioners

9. PPACA requires states to cover eligibility groups not previously covered.

10. Currently, Florida Medicaid has a variety of eligibility thresholds that depend on the age and condition of the recipient. Children from birth to 1, for example, are eligible if their family income does not exceed 185% of federal poverty level. Children from 1 through 5 are eligible if their family income does not exceed 133% of federal poverty level. Children 6 through 18 are eligible if their family income does not exceed 100% of federal poverty level. Children 19 and 20, as well as adults with children who are Medicaid-eligible, are eligible if their income does not exceed 22% of federal poverty level. Aged, blind, and disabled adults are eligible if their income does not exceed 74% of federal poverty level. Aged and disabled adults who need long term care (e.g. a nursing home) are eligible if their income does not exceed 222% of federal poverty level. Pregnant women are eligible if their income does not exceed 185% of federal poverty level. Women with breast and/or cervical cancer are eligible in their income does not exceed 200% of federal poverty level. Women who have lost Medicaid coverage for any reason are provided limited family planning services for up to 24 months through the Family Planning Waiver. The program does not currently serve able-

bodied, childless adults not otherwise covered in a current categorical coverage group.

11. Starting in 2014, PPACA requires that state Medicaid programs serve all individuals under 65 with incomes of up to 133% of the federal poverty level.[1] PPACA also requires a 5% income disregard for all populations (effectively raising the eligibility threshold to 138% of the federal poverty level). These newly-mandated populations ("newly eligibles") include childless adults whom the Florida Medicaid program has not previously served. It also expands eligibility in Florida for children ages 6-20 and for parents, the aged, the blind, and the disabled who do not need long term care.

12. PPACA provides for enhanced federal financial participation for the newly eligible populations. The Federal government uses the Federal Medical Assistance Percentage (or FMAP) to determine the amount of Federal matching funds for state's expenditures for assistance payments for certain social services, including Medicaid. Through the FMAP, the federal government has traditionally funded about 55% of the Florida Medicaid program, with Florida generally funding the other 45%. With respect to the newly eligible populations, the federal government will fund 100% of the cost of serving the newly eligible population from 2014 through calendar year 2016. Thereafter, states are required to start contributing to the cost of

[1] PPACA, § 2001(a).

serving the expansion population, with the federal government's share dropping to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond.

13. Currently, Florida has broad discretion to set reimbursement rates for health care providers who participate in the Medicaid program. Starting in state fiscal year 2012-13 (January 1, 2013), PPACA will require Florida to reimburse for certain primary care procedure codes used in the Medicaid program at a federally-mandated rate (in essence, they must be reimbursed at the same rate as in the federal Medi***care*** program). This requirement will continue through December 31, 2014. During this period the state will received 100% federal funding for the cost of the increased reimbursements. For estimation purposes, AHCA assumes that the federally-required rate increase would continue beyond the two-year period delineated in the law and these costs would then be partially funded with state funds.

14. AHCA has made projections regarding the fiscal and enrollment impact of PPACA, and presented its projections to the Florida legislature. The power point presentation created for this purpose is attached as Attachment 1 *(AHCA, Overview of Federal Affordable Care Act, August 18, 2010)*. The power point presentation describes the various assumptions that went into AHCA's projections, and these assumptions can be found at pages 4 through 10 of the presentation. *See* Attachment 1. This power point presentation was not prepared in

anticipation of litigation. AHCA officials prepared it and have maintained it in the regular course of their public business.

15. The AHCA presentation projects the estimated cost to Florida of $142,460,765.00 in state general revenue in Florida's 2013-2014 fiscal year. This amount increases going forward, and by 2018-19 the projected costs to Florida are estimated to be just over a billion dollars per year, or $1,012,206,268.00, in state general revenue.

16. When fully implemented, AHCA projects that PPACA will add an additional 1.8 million people to Florida's Medicaid annual rolls, meaning that the program will, by as early as 2015, serve more than 4.5 million people annually.

17. AHCA developed projections regarding the growth in costs and enrollment as a result of PPACA which project that PPACA will result in the expansion of the Florida Medicaid caseload in four ways. First, it will extend Medicaid to persons previously ineligible (the "newly eligible"). By SFY 2018-2019, AHCA projects that this population will cost Florida roughly $351 million per year in state revenue.

18. Second, AHCA projects that PPACA will increase program enrollment of uninsured persons who are currently eligible for Medicaid but who, for whatever reason, are not currently enrolled. By SFY 2018- 2019, AHCA projects that this population will cost Florida about $574 million per year in state revenue. The estimates developed reflect a higher commitment of state

general revenue as the state will continue to receive the regular FMAP rate for this population.

19. Third, AHCA projects that PPACA will prompt some low-income individuals, who will be newly eligible for the Medicaid program under PPACA, to drop their private insurance coverage and enroll in Medicaid. By SFY 2018- 2019, AHCA projects that this population will cost Florida almost $47 million per year in state revenue.

20. Fourth, AHCA's projects reflect the transition of coverage of some CHIP enrollees to coverage under the Medicaid program. AHCA projects that children between the ages of 6-18 in families with incomes between 100-133% of FPL and currently covered by CHIP will be enrolled in Medicaid. AHCA projects that, by SFY 2018-2019, this change will cost Florida about $78 million in state revenue a year, while saving the state CHIP program about $62 million per year, for a net cost of roughly $16 million per year in state revenue.

21. Also, AHCA's projections assume that the changes PPACA makes to physician reimbursement rates will cost Florida an additional $391 million per year in state revenue by SFY 2018-2019.

22. In sum, AHCA projects that the expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level will increase Florida's costs, less so in the early years but more so after 2016.

Restrictions on State Ability to Change Eligibility and Tailor Medicaid Programs

23. Traditionally, Medicaid programs have had some authority to develop eligibility standards, including reducing eligibility for groups above mandatory coverage levels. Starting on the date of its signing (March 23, 2010), PPACA takes this type of policy-making authority away. PPACA requires all states to maintain their current eligibility standards for adults through 2014, and for children through 2019. This is known as the "maintenance of effort" requirement.

24. The maintenance of effort requirement means that Florida cannot make any change to eligibility that would render a person ineligible for Medicaid or CHIP benefits when that same person would have been eligible for benefits on March 23, 2010. If Florida fails to comply with the maintenance of effort requirement, it risks losing federal matching funds for *all* Medicaid programs, including funds that support services to pregnant women, children, and the aged and disabled populations.

25. PPACA establishes separate maintenance of effort requirements for the adult and children's Medicaid populations and, as a result, alters the state's expectations for coverage of optional categorically needy populations. The maintenance of effort requirement for the adult Medicaid population will remain in place until the U.S. Department of Health and Human Services (HHS) determines that an exchange

established by the state under PPACA section 1311 is fully operational.[2] The maintenance of effort requirement for CHIP and the children's Medicaid population up to age 19 will remain in effect through September 2019.[3]

26. As stated previously, consistent with federal law, Florida has opted to cover, as optional categorically needy groups: pregnant women between 150 and 185% of federal poverty level; women with breast and cervical cancer up to 200% of federal poverty level; and persons in need of long term care (e.g. nursing home services) between 74% and 222% of federal poverty level.

27. AHCA created these groups according to policy direction from state leadership. The maintenance of effort provision precludes the state from reducing or eliminating these previously optional eligibility groups as a matter of policy.

Loss of Prescription Drug Rebate Revenue

28. PPACA modifies the minimum Medicaid federal unit rebate amount for most drugs.[4] These modifications were made retroactively effective to January 1, 2010, and have the effect of reducing the supplemental rebates available to the states.

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[2] PPACA, § 2001(b).

[3] *Id.*

[4] PPACA, § 2501.

29. CMS provided initial guidance to states regarding PPACA's pharmacy rebate provisions on April 22, 2010. In this initial guidance letter, CMS indicated that it would retain the difference between the old and new rebate percentages across the board for all drugs, not just for those drugs for which there is an actual increase in the federal rebate amount due to the Act. Final guidance was distributed to State Medicaid Programs on September 28, 2010. In this letter, CMS revised the previous instructions concerning the Federal offset of Medicaid prescription drug rebates. At this time, the Agency is still waiting for additional information from CMS so that the Agency can invoice for federal 2010 rebates for the Fee-For-Service program as well as begin invoicing for federal rebates based on utilization from the Medicaid Managed Care Plans.

30. AHCA currently estimates that Florida will lose approximately $40 million in rebate revenue from SFY 2010-2011 for those drugs for which we are receiving rebates in excess of the current minimums.[5] During that same timeframe, the state will receive approximately $551 million in rebate revenue.[6]

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[5] These projections were developed by AHCA based on SFY 2010-2011.

[6] *Id.*

The PPACA Depends Upon State Participation in Medicaid to Achieve Its Coverage Goals

31. The PPACA provides subsidies and credits for individuals between 133% and 400% of the federal poverty level who obtain qualified coverage through a health insurance exchange, but relies solely upon state participation in Medicaid to cover individuals up to 133% of the federal poverty level.

32. In Florida, Medicaid covers and pays for health care services for almost 3 million persons, including 27% of Florida's children; pays for over 50% of Florida childbirths; pays for 63% of nursing home days; delivers services through more than 80,000 individual providers and 23 managed care plans.

33. If Florida's Medicaid and CHIP programs were ended, no current program exists that would cover the healthcare costs of individuals at 133% of the poverty level and, absent planning and implementation of some programmatic substitute, Florida would face a health care emergency affecting its poorest and neediest citizens. If Florida were to cease participation abruptly without a programmatic substitute, it would likely result in severe health repercussions, including possible loss of life, among the most desperately ill and disabled within the current Medicaid population.

34. No known federal laws or regulations provide a non-abrupt process by which a state might make an orderly wind down or transition from

Medicaid in a manner that would safeguard the health care of current Medicaid beneficiaries.

C. Attachments

35. I have attached the following document to this affidavit, which are true and correct copies of the original as maintained by AHCA:

#	Document Description
1	*Fla. AHCA, Overview of Federal Affordable Care Act, August 18, 2010*

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 3, 2010, in Tallahassee, Florida.

_____

Elizabeth Dudek
Interim Secretary
Agency for Health Care Administration

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF JENNIFER LANGE

Pursuant to 28 U.S.C. § 1746, I, Jennifer Lange, declare the following:

1. I am making this affidavit in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.* The facts and statements in this declaration are true, correct, and within my personal knowledge.

2. I am the Director of the **A**utomated **C**ommunity **C**onnection to **E**conomic **S**elf-**S**ufficiency (ACCESS) Program in the Florida Department of Children and Families (DCF). I am responsible for administration of eligibility

requirements and determinations for the Medicaid Program in the State of Florida. I have held this position since April 2006.

3. I am a resident of the State of Florida; I am over the age of 21; and I make the statements in this declaration based upon my personal knowledge of analysis completed by DCF, with respect to the cost of implementing an adequate eligibility system related to the Medicaid programs that complies with or meets the requirements of the Patient Protection and Affordable Care Act (PPACA), H.R. 3590.

4. The Department of Children and Families' mission statement is "Protect the vulnerable, Promote strong and economically self-sufficient families, and Advance personal and family recovery and resiliency". We pursue our mission by, among other things:

    (a) Participating in the administration of social service funds under Title XX of the Social Security Act pursuant to section 409.031, Florida Statutes;

    (b) Participating in the eligibility determination of applicants for Florida Kidcare Program pursuant to section 409.810 *et seq.*, Florida Statutes;

    (c) Administering the eligibility determination of applicants for Florida Medicaid Program pursuant to section 409.902 *et seq.*, Florida Statutes; and

    (d) Administering the eligibility determination of applicants for the

Florida Cash Assistance Program pursuant to chapter 414, Florida Statutes.

5. DCF has completed a high-level estimate of the impact of the PPACA and work that is required for the development and enhancement of DCF systems to meet the PPACA's requirements.

6. While the PPACA requires full implementation of Medicaid program changes by January 2014, technology programming must be completed sooner and require a multi-year effort beginning in 2011 to implement federal eligibility requirements in support of the PPACA.

7. To support the requirements identified in PPACA, DCF must retool the Medicaid eligibility determination component of its eligibility systems and informational web pages. PPACA also requires states to develop electronic interfaces with health subsidy programs including the American Health Benefit Exchanges.

8. DCF understands the PPACA will expand eligibility to individuals not currently covered by or eligible for Medicaid, such as individuals under age 65 with countable incomes of up to 133% of the federal poverty level, including adults who are neither disabled nor pregnant, which DCF anticipates will increase Florida's Medicaid rolls by at least 1.5 million individuals in the PPACA's early years after full implementation.

9. To accomplish the necessary programming during fiscal year (FY) 2011-12, DCF Information Systems staff project that the Department must spend $5,097,600 for FLORIDA system reprogramming ($2,528,800 in state funds and $2,528,800 in federal matching funds). Additional funding, currently estimated at $1,274,400, (half state and half federal) will be needed for FY 2012-13 to complete the programming of systems requirements not completely known at this time. The total initial estimated project cost is $6,372,000. Programming costs may change as additional requirements become defined or apparent for changes that must be in place and operational by January 1, 2014.

10. Twelve additional program office staff have been requested to start employment beginning in FY 2011, to prepare, plan, design and monitor the policy and technology needs of the expanded Medicaid system. These staff would coordinate with the Agency for Health Care Administration (AHCA) and the state health care exchanges to ensure appropriate information sharing, planning and interfaces.

11. Federal law in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, Public Law 104-193), requires states to provide medical assistance under Medicaid to individuals who meet the eligibility requirements or are included in a state plan under Title IV-A of the Social Security Act as in effect prior to passage of PRWORA. This includes children in Foster Care or Adoption

Assistance Programs under Part E and very low income families who would have qualified under the old Aid to Families with Dependent Children welfare program. Florida currently covers these individuals through Medicaid and receives federal matching funds to help cover the costs. Failure to provide Medicaid to these individuals could jeopardize Florida's TANF block grant.

12. Florida's federal TANF block grant is more than $562 million annually. These funds could be lost if Medicaid were discontinued or terminated for the above referenced individuals.

13. I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's implementation and as AHCA and the North Florida Shared Resource Center receive more guidance from the appropriate participating entities. The statements pertain to DCF ACCESS and do not include assessment of impact of costs to other entities.

Executed on November 3, 2010, in Tallahassee, Leon County, Florida.

_____

JENNIFER LANGE
Director, ACCESS Program
Florida Dept. of Children and Families

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF J. BEN WATKINS, III

Pursuant to 28 U.S.C. § 1746, I, J. Ben Watkins, III, declare the following:

1. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the State of Florida (the "State") as the Director of the Florida Division of Bond Finance.

2. I declare that the statements made herein are based upon my personal knowledge, the Florida Statutes and State Constitution, and upon the records of the State.

3. The State is required by its Constitution to raise "… sufficient revenue to defray the expenses of the state for each fiscal period." Article VII, Section 1(d), State Constitution. Accordingly, deficit spending is not permitted by the State.

4. The Governor is required to prepare a balanced budget of State expenditures. Section 216.162, Florida Statutes. If the Governor determines, at any time, that the recommended budget will no longer be in balance with estimated revenues, the Governor must amend the revenue or expenditure recommendations to bring the budget into balance. Section 216.168(4) Florida Statutes.

5. It is the duty of the Governor and the Chief Financial Officer to ensure that revenues being collected by the State will be sufficient to fund appropriations and that no deficit will occur in any fund of the State. Sections 216.221(1) and (8), Florida Statutes.

6. If a deficit occurs in the General Revenue Fund of the State, specific procedures are established for rectifying the budget deficit and maintaining a balanced budget, including the transfer of reserve funds to correct the deficit. Section 216.221, Florida Statutes.

7. The State's reserves have been reduced from a high of $6.1 billion at June 30, 2006, to $837 million expected at June 30, 2011.

8. State reserves have been used to mitigate spending reductions that would have otherwise been necessary to balance the State's budget.

9. The State is confronted with a projected budget deficit for fiscal 2011-12 of $2.5 billion, assuming that State General Revenue Fund reserves have been fully exhausted.

10. The State has experienced negative changes to the ratings on its debt due to difficult financial conditions. On December 11, 2008, Fitch Ratings revised its outlook for the State from stable to negative. This change was due to "… economic and revenue deterioration as well as the significant uncertainty associated with the economic and revenue outlook."

11. On January 1, 2009, Standard & Poor's Ratings Services also revised its rating outlook on the State's full faith and credit debt to negative from stable. The change was due to several factors including declining state revenues which resulted in spending reductions and a reliance on reserves to balance the State budget. The negative outlook continues to be in effect and reflects Standard & Poor's view that the State continues to confront continuing economic and financial pressure.

12. The State Constitution authorizes the State to borrow money by issuing bonds for fixed capital outlay projects only such as schools, roads and land acquisition. Articles VII and XII, State Constitution. The Constitution does not provide for borrowing for operating expenses.

13. The State's financial flexibility to absorb additional spending requirements from health care reform is severely impaired and borrowing

money to provide funding is not permitted by the State Constitution.

14. The State's credit rating and continued access to low-cost borrowing to fund investment in infrastructure may be jeopardized by budget imbalances. A downgrade of the credit rating would adversely affect the State's cost of borrowing to meet its capital needs.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed at Tallahassee, Florida, this 3rd day of November, 2010.

_____

J. Ben Watkins, III
Director, Florida Division of Bond Finance

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF JOANNE LEZNOFF

Pursuant to 28 U.S.C. § 1746, I, JoAnne Leznoff, declare the following:

1. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the State of Florida, House of Representatives, as the Staff Director of the Appropriations Committee. As the Staff Director for the Appropriations Committee, I am the lead staff responsible for among other things, the preparation General Appropriations Act for the House of Representatives ensuring that the budget is technically correct, balanced as required by the Florida Constitution and

consistent with law. Prior to assuming this role I was a Deputy Budget Director in the House of Representatives responsible for various aspects of budget development and coordination. Prior to my tenure in the House I served in various budget related capacities in the Governor's Office of Policy and Budget and as the Director of Financial Management for the Department of Corrections. I have over 23 years of experience in state government over 10 of which have been directly related to budget.

2. I declare that the statements made herein are based upon my personal knowledge and upon the records of the State of Florida.

3. Florida's Constitution provides authority to the Florida Legislature to exercise powers reserved to the States under the United States Constitution, including the power to pass laws that make appropriations.

4. The Florida Constitution also requires that provision be made in law that raises sufficient revenue to defray the expenses of the State for each fiscal year.

5. The State of Florida's budget for Fiscal Year ("FY") 2010-11 is $70.5 billion ($43.4 billion of which is comprised of state funds). From that total budget, the State pays for infrastructure and services including but not limited to education, law enforcement, judiciary, corrections, and healthcare services.

6. The State has limited sources of funds to provide for infrastructure and services, primarily its

own source taxes and fees, and funds provided by the federal government. Additionally, Florida's Constitution allows limited borrowing for capital projects, such as school buildings, prisons, roads, and for environmentally sensitive lands.

7. Florida's Constitution also constrains the State's ability to increase revenue through increased taxation. For instance, personal income and inheritance taxes are prohibited, and other taxes are capped (intangibles tax) or require super-majority votes (corporate income tax).

8. The State of Florida has faced billions of dollars in budget shortfalls for the past several years. At the same time, the State's funding obligation to Medicaid has been substantial. Over the last decade, the State Medicaid Program has been the single largest cost driver of all government programs. At a cost of approximately $20 billion, Medicaid will serve an estimated 2.9 million Floridians in FY 2010-2011. The Medicaid program constitutes over 28 percent of the funds appropriated in the Florida State budget for FY 2010-11. The Patient Protection and Affordable Care Act of Congress ("PPACA") will significantly change the nature of Medicaid, greatly expanding both the costs and the obligations incumbent upon the State of Florida. Florida's Agency for Health Care Administration ("AHCA") estimates that these mandates may increase the State's Medicaid outlays by $1 billion or more annually by 2019.

9. Assuming the continuation of current or estimated fiscal conditions, funding the added costs imposed on its Medicaid program under the PPACA would present a significant challenge to the State of Florida. To provide that funding, the State likely would have to reduce its funding of other priorities or raise revenues. The federal portion of Medicaid funding appropriated for FY 2010-11 exceeds $12 billion and is equivalent to more than 27 percent of the total state funds in Florida's FY 2010-11 budget as well as comprising over 60 percent of the Medicaid budget. If the State of Florida were to cease participation in the Medicaid Program, the State by itself could not reasonably afford a comparable program, which would require in excess of a doubling of the outlays of state funds now devoted to Medicaid.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed at Tallahassee, Florida, this 3rd day of November, 2010.

_____

JoAnne Leznoff
Staff Director, Appropriations Committee
House of Representatives
State of Florida

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF MICHELLE ROBLETO

Pursuant to 28 U.S.C. § 1746, I, Mary Michelle Robleto, declare the following:

1. I am the Director of the Florida, Division of State Group Insurance (DSGI) and am responsible for employee benefit administration for the State of Florida. I have held this position since July 27, 2007.

2. I am a resident of the State of Florida; I am over the age of 21; and I make the statements in this declaration based upon my personal knowledge and upon the books and records of the DSGI.

3. I am making this affidavit in connection with *State of Florida, et al. v. United States*

Department of Health and Human Services, et al., a lawsuit to which the State of Florida is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge.

4. DSGI is created and governed by Florida Statutes chapter 110.123, and the regulations in Florida Administrative Code (FAC) chapter 60P.

5. DSGI administers the health, dental, vision, life, long-term disability and flexible spending account insurance programs for all eligible State officials and employees, and retirees who have chosen to participate in the DSGI insurance programs pursuant to Fla. Stat. § 110.123 (Florida State Group Insurance Program).

6. DSGI also provides assistance to participants (employees, retirees and their dependents) with questions regarding eligibility, access to services and claims, including a claim appeal process.

7. The Florida State Group Insurance Program offers a selection of comprehensive benefit programs, including both fully insured Health Maintenance Organization (HMO) options and a self-insured group Preferred Provider Organization (PPO) option. The administration and funding of the State's benefit programs is through the State Employees' Health Insurance Trust Fund, Fla. Stat. § 110.123(6).

8. About 142 thousand of Florida's state employees participate in the Florida State Group Plan administered by DSGI. About 30 thousand state employees, who work 30 or more hours a week,

do not participate in Florida State Group Plan either by choice or because Florida law excludes them from participation.

9. Federal health care reform, formally known as the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA), requires DSGI to amend the Florida State Group Plan and to offer PPACA prescribed benefits not currently offered, including:

    - extending dependent coverage to age 26 effective with the plan year beginning January 1, 2011;
    - removal of any lifetime policy limit provisions effective with the plan year beginning January 1, 2011; and
    - removal of pre-existing conditions limitations on persons to age 19, effective with the plan year beginning January 1, 2011.

10. The Division of State Group Insurance (DSGI) commissioned actuarial consulting services from Mercer Health & Benefits, LLC, under Requisition Number PR4753007-V2. The resulting work product, "Estimating the annual financial impact of federal health reform for FY 2010-11 through FY 2014-14," dated September 1, 2010 was accepted by DSGI and paid under Purchase Order A2590D.

11. Per the Mercer report, as a result of PPACA's requirements that additional benefits be given to officers and employees in the Florida State

Group Plan, increased costs will be imposed on DSGI.

12. Per the Mercer report, PPACA's requirement that DSGI expand dependent coverage to age 26 has a projected cost of $37.3 million, for the period fiscal year (FY) 2010-11 through FY 2013-14.

13. Per the Mercer report, PPACA's requirement that DSGI remove lifetime policy limits has a projected impact of $11 million for the period FY 2010-11 through FY 2013-14.

14. Per the Mercer report, PPACA's requirement that DSGI remove pre-existing conditions limitations on persons to age 19 has a projected impact of $6.2 million for the period fiscal FY 2010-11 through FY 2013-14.

15. By 2014, PPACA requires that Florida offer enrollment to all employees working 30 or more hours a week into the expanded Florida State Group Plan or pay an annual penalty based on the size of its entire workforce. Per the Mercer report, if the state decided to drop health coverage, the estimated penalty would exceed $330 million.

16. Per the Mercer report, in response to the PPACA's employer enrollment mandate and its mandate that individuals have qualifying coverage (such as through an employer plan), or pay a penalty to the federal government, DSGI expects over 20,000 additional state employees to enroll in the Florida State Group Plan at a cost of between $200 and $300 million in 2014.

17. Many of the state employees that will be newly eligible to enroll in the Florida State Group Insurance Program because of the employer mandate are designated currently as "other-personal-services" (OPS) employees (*see* Fla. Stat. § 110.123(2)(c) & (f)), who work more than 30 hours a week, but are not currently eligible for coverage in the Florida State Group Insurance Program pursuant to Florida law.

18. I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on October 21, 2010, in Tallahassee, Florida.

_____

Michelle Robleto
Director, DSGI

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF PAT SHIER

Pursuant to 28 U.S.C. § 1746, I Pat Shier, declare the following:

I am the Director of the Division of Retirement and Benefits (Division), Department of Administration, State of Alaska. I have been in this position since 2006. I have personal knowledge of the matters set forth in the Declaration.

The Division that I direct is responsible for administering state employee pension programs. Additionally, the Division administers that active and retiree health plans collectively referred to as the AlaskaCare Health Plans. Detailed information relating to both the pension plans and the

AlaskaCare Health Plans is available on the Division's website at http://doa.alaska.gov/drb/. The Division's statutory authority to make assessments and projections relating to the active employee AlaskaCare Health Plan is derived from AS 39.30.090 - .098. As of July 1, 2009, the third party administrator for the Division is Wells Fargo Insurance Services of Alaska, Inc. (WFIS). The Division also maintains a contract with Buck Consulting Services, Inc. (Buck) for actuarial Services relating to the pension and health plans. The Division's statutory authority to retain WFIS and Buck for Services relating to the AlaskaCare Health Plan is derived from AS 39.30.090 – .098, AS 39.35.001 – .990; AS 14.25.009 – .220; and AS 22.25.010 – 090.

Providing this Declaration is within the scope of my authority, and I submit that the representations are truthful and accurate.

I confirm that both state officers and employees participate in the active employee AlaskaCare Health Plan.

Requirements and Costs for Alaska Employee Health Plan Under ACA

I confirm that the Patient Protection and Affordable Care Act (ACA) requires the Division to amend the active employee AlaskaCare Health Plan and offer certain ACA-prescribed benefits to members in the next effective plan year following September 23, 2010, as follows: (1) pursuant to ACA § 1201 (inserting § 2704 into the Public Health Service Act ("PHSA")), the Division will amend its active employee health plan to eliminate preexisting

conditions for individuals under age 19 July 1, 2011; and (2) pursuant to ACA § 1001 (PHSA § 2718), by July 1, 2011, the Division will amend its active employee health plan to include coverage of dependents under age 26 who do not have coverage elsewhere.

The Division's actuarial consulting firm, Buck, estimates an increased cost due to covering dependents up to age 26 who do not have coverage elsewhere to be $275,341 in 2011. The State's actuarial consulting firm estimates no measurable costs increase following the removal of the pre-existing condition for children under age 19.

The statements and assessments stated herein are complete and accurate to the best of the Division's knowledge as of the date of this Declaration, and may be subject to revision as additional data are generated over time and as the ACA is amended or as regulations pursuant to the ACA are announced and implemented by federal agencies.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 3rd day of September, 2010.

By: _____

Pat Shier, Director
Division of Retirement and Benefits
Department of Administration
State of Alaska
6th Floor State Office Building
P.O. Box 110203
Juneau, Alaska 99811-0203

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF WILLIAM L. ASHMORE

Pursuant to 28 U.S.C. § 1746, I William L. Ashmore, declare the following:

1. I am a resident of Montgomery County, Alabama, am over the age of 21 years, and I have been the Chief Executive Officer for the State of Alabama Employees Health Insurance Board since 1990. I have read the complaint filed in the above-styled lawsuit, and am familiar generally with the allegations contained therein. I have personal knowledge of the facts and matters stated within this declaration.

2. A state-wide health insurance program for employees and officers of the State of Alabama

was enacted in Alabama Acts 1965, No. 65-833, and various Acts enacted thereafter (all of which are now codified at *Ala. Code* § 36-29-1, *et seq.*).

3. *Ala. Code* § 36-29-2 established the State Employees' Health Insurance Board (hereinafter "the Board"), which is an agency of the State of Alabama. Pursuant to *Ala. Code* §§ 36-29-3 and 36-29-4, the Board was empowered and authorized to establish and administer a health insurance plan for employees and officers of the State of Alabama.

4. As a result of my long-standing service in the above capacity with the Board, I am knowledgeable concerning the development, implementation and operation of the State Employees Health Insurance Plan (hereinafter referred to as "SEHIP"). In my capacity as Chief Executive Officer of the Board one of my responsibilities is to keep abreast of health insurance trends not only for the SEHIP, but on a regional and national level as well. I continuously review and analyze claims data of the SEHIP in conjunction with national and regional trends in order to assess and project the effect on the SEHIP.

5. *Ala. Code* § 36-29-7 requires that the Chief Executive Officer of the Board certify after proper evaluation that any changes in the SEHIP are justified. Accordingly, the effect on the SEHIP of the Patient Protection and Affordable Care Act (hereinafter "ACA") are within my official duties. It is essential to the financial well-being of the SEHIP that my

projections relating to the changes mandated by the ACA be as accurate as possible.

6. *Ala. Code* § 36-29-7 and § 36-29-15 provides that state officers and employees may participate in the SEHIP. The plan currently covers 37,265 active employees and 19,280 retired employees.

7. The SEHIP meets the definition of an employer group health plan covered under the ACA. At its September 1, 2010 meeting, the Board amended the SEHIP to incorporate the following provisions of the ACA: (1) new preexisting condition requirements for individuals up through age 18 (ACA § 1201 (inserting § 2704 into the Public Health Service Act ("PHSA")); (2) exclusions for excessive waiting periods (ACA § 1201 (PHSA § 2708)); (3) lifetime and annual policy limit provisions (ACA § 1001 (PHSA § 2711)); (4) prohibition on rescission of coverage (ACA § 1001 (PHSA §2712)); (5) dependent coverage requirements (ACA § 1001 (PHSA § 2714)); (6) and reporting requirements (ACA § 1001 (PHSA § 2718)). These changes will become effective for the plan year beginning January 1, 2011.

8. As a result of the ACA's immediate requirements that additional benefits be given to employees and officers covered under the SEHIP, increased costs will be imposed on the State of Alabama.

9. Based on my experience with the SEHIP and an analysis of the additional benefits mandated by the ACA, I project that these additional benefits will increase the cost of the SEHIP by at least

$2,900,000 in 2011. This projected cost will be significantly higher in future years as additional mandated benefits are imposed by the ACA.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 7th day of September, 2010.

_____

William L. Ashmore, Chief Executive Officer
State of Alabama Employees Insurance Board
201 South Union Street, Suite 200
Montgomery, Alabama 36104

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF KAREN BATTILANA

Pursuant to 28 U.S.C. § 1746, I, Karen Battilana declare the following:

1. I am an adult resident of the State of Arizona and I make the statements in this declaration based upon my own personal knowledge and upon the books and records of the Arizona Department of Administration.

2. I am the Assistant Director of the Benefit Services Division for the Arizona Department of Administration, responsible for employee benefit administration. I have held this position since November 2009.

3. The Benefit Services Division (BSD) administers the health, life, dental, vision, and flexible-spending insurance programs for all eligible state employees and those state retirees who choose the State of Arizona's Benefit Options Plan (the "Plan"). The BSD also assists members (employees, retirees, and dependents) with problems of access to services, eligibility, and claims.

4. The State of Arizona offers a comprehensive self-insured group medical insurance program to all State employees, retirees, and public officers. The administration and funding of State's self-insured program is through the Health Insurance Trust Fund (HITF).

5. Federal health care reform, formally known as the Patient Protection and Affordable Care Act (H.R. 3590) ("ACA"), requires the State of Arizona in 2010 to amend its Plan and offer ACA-prescribed benefits to recipients, including: (i) removal of any lifetime and annual policy limit provisions (ACA § 1001 (PHSA § 2711)); and (ii) dependent coverage requirements (ACA § 1001 (PHSA § 2714)).

6. ACA further requires the State of Arizona in 2014 to amend its Plan to include ACA reporting requirements (ACA § 1001 (PHSA § 2718)).

7. As a result of ACA's immediate requirements that additional benefits be given to officers and employees in Arizona's Plan, increased costs will be imposed on the State of Arizona.

8. ACA's immediate requirement that expands dependent coverage to age 26 has a projected increased cost of $12,050,000 for the 2011 Plan Year and a projected net increase of 3,000 new Plan participants.

9. ACA's immediate requirement that removes lifetime and annual policy limits has a projected increased cost of $ 1,217,000 for the 2011 Plan Year.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 26th day of August 2010, Phoenix, Arizona.

_____

Karen M. Battilana,
Assistant Director
Arizona Department of Administration,
Benefit Services Division

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF THOMAS J. BETLACH

Pursuant to 28 U.S.C. § 1746, I, Thomas J. Betlach, declare the following:

1. I am the Director of the Arizona Health Care Cost Containment System ("AHCCCS"), Arizona's single State Medicaid agency.
2. I have worked in the AHCCCS program both as Director and Deputy Director for over eight years.
3. I have personal knowledge of the Medicaid program in Arizona and the impact of the Patient Protection and Affordable Care Act (the "Act") on the AHCCCS program.

4. The sections that follow provide further information on the Act's injurious impact on AHCCCS and, if called to testify as a witness, I could explain that impact competently.

A. Medicaid Program Prior to the Act

1. Arizona's Medicaid Program, known as the Arizona Health Care Cost Containment System ("AHCCCS"), began in 1982.

2. When the State entered into the Medicaid Program, the State understood it to be a state/federal partnership that allowed state flexibility and control over a variety of aspects of the program. This allowed states to specifically construct a Medicaid Program that is (a) tailored to meet the needs of its citizenry and (b) within its budgetary means.

3. It was Arizona's expectation that the terms of its participation in Medicaid would not be altered significantly by the federal government to expand eligibility for enrollment beyond the State's ability to fund its participation. There are certain coverage groups that have always been optional within the Medicaid Program and Arizona fully expected those groups to remain optional, at the discretion of the State, for purposes of participation within AHCCCS. The reason for this flexibility is so that the states could ensure that they were meeting the needs of the most vulnerable within their state while still living within budgetary constraints of state government.

4. Moreover, it was always Arizona's understanding that the Medicaid Program required Arizona to provide payment for medical services, as opposed to actually providing medical services as now defined under the Act.

5. Finally, Arizona entered into the Medicaid Program with the understanding that Medicaid was a partnership between the states and the federal government. The role of the federal government in the Medicaid program, as understood by Arizona at the time it began participation, was not one of coercion. Had Medicaid been an all or nothing proposition at the outset, Arizona's decision making with respect to its level of participation in the Medicaid program would clearly have been impacted both at its inception and when contemplating future expansions.

B. The Act's Injurious Impact on the Federal-State Healthcare Partnership

1. The Act eliminates Arizona's flexibility with respect to eligibility. The states used to have flexibility to carve a Medicaid program that the state felt was best suited to caring for its most vulnerable and still fell within state budgetary constraints. Defining eligibility was a key part of that flexibility that was completely eliminated by the Act. Arizona is now locked into a program that is covering over 200,000 childless adults, over 120,000 parents in an optional category and several other optional populations. Arizona has exercised the option to allow persons with an institutional level of need to participate in the

program up to 300% of the Federal Benefit Rate. AHCCCS also elected a parental income disregard for children with an institutional level of need. The State also provides coverage under the Breast and Cervical Cancer Treatment Program and Ticket to Work. These are examples of options the State has elected that now have become mandated. These are also examples of options that, during this major recession, the State simply cannot afford, but the Act has forced Arizona to retain them in the program.

2. The Act essentially requires the State to make cost-saving adjustments to the AHCCCS Program on the backs of its providers. Medicaid funding is a three-legged stool, in essence – eligibility, provider reimbursement and benefits. The Act prohibits states from adjusting eligibility. Thus, states can make changes to benefits and provider rates. Changes to benefits may save money in the short term but often are more costly in the long term because managing a member's care is more effective than paying for emergency care. Arizona has already reduced benefits by over $6 million (General Fund). Meanwhile, the real dollar savings comes from reducing rates. Provider reimbursement is critical to maintaining access to care and an adequate provider network that will meet the needs of the Medicaid members. The states cannot so damage their relationships with providers by reducing reimbursement to a point where providers are no longer willing to accept Medicaid patients. Providers should be

reimbursed fairly and adequately for the care they provide. The Act disregards this issue and forces states to reduce provider rates. Arizona has reduced payments to providers by $555,820,800 (Total Fund). In addition, recent Ninth Circuit Court of Appeals decisions regarding Section 1902(a)(30)(A), have imposed significant and costly administrative burdens on states considering provider rate reductions.

3. The Act allowed managed care organizations (MCOs) to participate in the drug rebate program for the first time. Because of the pharmaceutical industry's response, it will end up expending a lot of administrative resources for very little gain to the State. Already the process to come into compliance with the drug rebate program has required the reallocation of scarce internal resources.

4. Arizona is currently undergoing review as to whether the State will operate its own Exchange. Regardless of the outcome of that policy decision, AHCCCS will have to upgrade its eligibility systems in order to be interoperable with the Exchange such that it can screen for Medicaid/CHIP. The State will also need to acquire resources and expert staffing in order to address Exchange requirements relating to instituting regulations, consumer protections, rate reviews, solvency and reserve fund requirements, and premium taxes. Looking to the Massachusetts example, that state needed $25 million on front end costs for Exchange and currently spends $30 million per year (funded largely through user fees).

Massachusetts' up front costs were largely funded by their State General Fund. Arizona is currently not in any position to provide that type of start up funds.

5. The expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level will increase Arizona's costs, less so in the early years but more so after 2016. Arizona anticipates that the mandated expansion coupled with the woodwork effect of the individual mandate and maintenance of eligibility of previously optional groups is estimated to cost the State between $7.5 billion and $11.6 billion (General Fund) from 2011 to 2020.

6. The Act's requirement that Arizona be responsible for providing healthcare services to Medicaid enrollees (as distinguished from providing healthcare funding) will almost certainly expose the State to increased costs and litigation risks. Neither the Medicaid Act nor state law gives the State Medicaid agency any authority to compel providers to render care to Medicaid patients. The only way to encourage provider participation is to raise payment rates, which is not feasible at this time.

C. The Act's Injurious Impact on Your State

1. Based on 2008 Census Bureau statistics, Arizona has nearly 1.2 million uninsured individuals. Of those, approximately 223,000 are below 133 percent of the federal poverty line and

must be added to the AHCCCS program as required by the Act.

2. Medicaid outlays for Arizona consume roughly 20 percent of the State's budget. For FY 2009-2010, Arizona spent nearly $2 billion on Medicaid, servicing approximately 1.35 million persons.

3. It is not now feasible for Arizona to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid-like program. The AHCCCS program accounts for approximately $9.5 billion in health care spending for the State of Arizona. Funding to hospitals alone accounts for nearly 40 percent of that spending. Moreover, AHCCCS members are integrated within the overall Arizona health care delivery system. That means that Medicaid members rely on the very same providers from whom all Arizonans receive care. Eliminating Medicaid would mean that hospital uncompensated care would skyrocket, hospitals would have to close certain departments, stop expansion projects, and physicians would see a loss in revenue. In addition, community health centers would see a severe decline in their insured patient mix. The hit to Arizona's health care system would be devastating.

4. The added costs to Arizona under the Act would not be offset by increased federal contributions under the Act. In fact, Arizona believes that overall, the Act will cost the State $7.5 billion to $11.6 billion (General Fund) from 2011 to 2020.

5. One of the most difficult aspects of the Act is allocating scarce resources in order to implement the Act's requirements. There are numerous provisions directly impacting the Medicaid program. Then there are a variety of other provisions that will require action on the part of State Medicaid programs, like the Exchange. The AHCCCS Administration is down 31% in staff, representing a reduction of over 400 employees. Meanwhile, our membership has grown by over 300,000. The AHCCCS Administration has made reductions and streamlined administrative functions wherever possible, including mandatory furlough days. Currently, all staff is focused on only critical core Medicaid functions. The Act has disrupted this focus and mandated how the State allocates scarce resources. Almost overnight, AHCCCS has had to devote funds and human resources to implement changes such as enforcing immediately-effective provisions of the Act; determining gaps between current State resources and resources that are projected to be needed to comply with the Act; evaluating current State infrastructure to determine how to implement new programs and to expand existing programs to comply with the Act; developing a strategic plan and coordinating the plan across various affected State agencies; initiating legislative and regulatory processes to comply with the Act; being familiar and dealing with federal regulatory processes to protect State interests; deciding whether to participate in optional programs under the Act; developing

communications to disseminate information regarding changes brought about by the Act to affected persons or entities in Arizona.

6. These added costs under the Act will have a significant effect on Arizona's fiscal state, lessening the General Fund's discretion to fund other critical needs such as education, corrections, law enforcement and more. To mitigate this crisis, Arizonans overwhelmingly voted to raise their own taxes by supporting a one cent sales tax increase under the leadership of the Governor. Nevertheless, the Act's mandates coupled with the end of the ARRA stimulus funding will still leave a $1 billion shortfall in the AHCCCS program.

D. Your State Cannot Avoid the Act's Requirements and Effects

1. If Arizona terminates its participation in Medicaid, 1.35 million of its most vulnerable citizens would be left without access to the healthcare services they have depended on for years under the AHCCCS program. Such an occurrence is unfathomable. Regardless, there are some within the state legislature and elsewhere who believe opting out of Medicaid is the only solution.

2. As partly noted above, ending Arizona's participation in Medicaid would devastate the overall health care system upon which all Arizonans rely. Medicaid has been critical to allowing the growth and development of Arizona's hospitals to meet the demands of a growing Arizona population since the inception

of the Medicaid program. Medicaid funding has been a significant part of hospitals' ability to gain a payor source for what was previously uncompensated care, allowing them to expand their physical capacity and develop centers of excellence that can now treat Arizonans for all their health care needs. Arizona's safety net hospitals would be completely devastated and would have to shut down beds and close down entire areas. Community Health Centers would also be hurt by the elimination of Medicaid. Since they serve as a critical safety net, having Medicaid as a payor is tremendously important. There also are so many Arizona physicians who are dedicated to caring for Arizona's most vulnerable citizens. These physicians would not be able to continue their mission without Medicaid as a payor. Of particular concern would be the impact to behavioral health providers, nursing facilities and home and community based services providers who are largely dependent on Medicaid. Finally, the impact to ancillary services, such as labs, transportation companies, etc., that support the health care community cannot be underestimated. These are important businesses in Arizona. Combined, the termination of Medicaid would not only harm health care but impact the State's economy and increase job losses.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 26th day of August 2010, Phoenix, Arizona.

_____

Thomas J. Betlach
Director,
Arizona Health Care Cost Containment System
801 East Jefferson, MD-4100
Phoenix, Arizona 85034

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-4

DECLARATION OF PAT CASANOVA

Pursuant to 28 U.S.C. § 1746, I, Pat Casanova, duly affirm under penalties for perjury that I am over 18 years of age and am competent to testify in a court of law:

1. I am the Director of Medicaid within the Indiana Family and Social Services Administration ("FSSA").

2. I have been the Director since March 2009 and, prior to that, I served as a director of Agency Coordination, Integration and Policy for the Office of Medicaid Policy and Planning ("OMPP") and in various other state governmental capacities for sixteen years.

3. The OMPP is responsible for setting policy within the FSSA for Medicaid and CHIP eligibility, rate-setting and reimbursement, and types of coverage/benefits for the citizens of Indiana. The OMPP also manages large contracts, such as those for claims processing and other business processes.

4. I have personal knowledge of the Medicaid program in Indiana.

5. Based in part on analyses competently and knowledgeably prepared by Milliman, Inc., the State's actuary, and attached as Exhibit A, I have knowledge of the impact of the Patient Protection and Affordable Care Act (the "Act") on the State's Medicaid program.

The Act's Injurious Impact on the Federal-State Healthcare Partnership

6. Indiana has always had, and has effectively utilized, the ability to control its costs by defining eligibility and benefits under its Medicaid program. The Act limits this flexibility.

7. While the Act does include 100% Federal funding to increase primary care physician reimbursement to 100% of Medicare for certain primary and preventative care services, the funding is only available for 2013 and 2014 and no Federal funding is available for other physician specialists or the full set of physician services. Thus, it appears that Indiana may be required to fund a substantial portion of the increase, estimated to be approximately $600 million for the period from January 1, 2014

through June 30, 2020, to ensure access to health care services for the current and newly eligible populations.

8. According to actuarial analysis, it is estimated that expanding Medicaid coverage to include all individuals under age 65 with incomes up to 138 percent of the federal poverty level will increase eligibility in Indiana by 413,000 parents and adults. In addition to the parents and adults, an additional 109,000 currently eligible children may enroll in Medicaid. This dramatic increase will lead to nearly 25% of Hoosiers being eligible for Medicaid.

9. By requiring that Indiana be responsible for providing healthcare services to Medicaid enrollees (as distinguished from providing healthcare funding), the Act may expose the State to increased costs and litigation risks. Neither the Medicaid Act nor State law gives the OMPP the authority to compel physicians to provide services to Medicaid patients.

The Act's Injurious Impact on Indiana

10. Based on 2008 Census Bureau statistics, Indiana has 744,600 uninsured persons living there. Of those, 274,000 are below 138 percent of the federal poverty line and must be added to the State's Medicaid rolls under the Act.

11. Medicaid outlays for Indiana consume almost 13% percent of the State's budget. For FY 2010-2011, Indiana will spend approximately $1.9 billion on Medicaid Assistance, servicing more than 1,000,000 persons.

12. It is not now feasible for Indiana to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid-like program prior to the Act taking effect.

13. The added costs incurred by Indiana under the Act would not be offset by increased federal contributions under the Act. Indeed, the total fiscal impact to Indiana's budget during the next ten years is estimated by the State's actuary to be between $2.6 billion and $3.1 billion.

14. The Act requires that State agencies begin to immediately devote funds and human resources to implement the mandated changes, such as enforcing immediately-effective provisions of the Act; determining gaps between current State resources and resources that are projected to be needed to comply with the Act; evaluating current State infrastructure to determine how to implement new programs and to expand existing programs to comply with the Act; developing a strategic plan and coordinating the plan across various affected State agencies; initiating legislative and regulatory processes to comply with the Act; being familiar and dealing with federal regulatory processes to protect State interests; deciding whether to participate in optional programs under the Act; and developing communications to disseminate information regarding changes brought about by the Act to affected persons or entities in Indiana.

Indiana Cannot Avoid the Act's Requirements and Effects

15. No State has ever dropped out of Medicaid.

16. Indiana has no other parallel Medicaid-like program that can substitute or provide Medicaid-like benefits should Indiana's Medicaid Program be terminated.

17. If Indiana were to end its participation in Medicaid, it would likely leave many of its citizens and residents without access to the healthcare services they have depended on for years under Indiana's Medicaid Program.

Qualifying Attached Exhibits Prepared by Outside Firm

18. Indiana Code § 12-8-1-7 gives the secretary of FSSA the power to employ experts and consultants to carry out the duties of the secretary and the offices. Under this power, the Secretary of FSSA hired Milliman, Inc. to provide consulting services related to the financial review of the Act as it relates to the provisions impacting the State's Medicaid program and budget.

19. It is the OMPP's duty to make assessments and projections as the need arises and it is the agency's regular practice to do so. Milliman was asked to create Exhibit A pursuant to that practice, by persons with knowledge, and contemporaneously with the obtaining of the reported information. The OMPP provided information for the report, has reviewed it, and is satisfied that it is reliable and trustworthy. The Exhibit was not created in anticipation of litigation.

20. The assessments and projections stated herein are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision (a) as additional data are generated over time and (b) as the Act is amended or as regulations pursuant to the Act are announced and implemented by federal agencies.

21. I hereby certify to authenticity of the Exhibit.

22. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 3rd day of November, 2010.

_____

Pat Casanova
Director of Medicaid
302 West Washington Street
Indianapolis, Indiana 46204

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-4

DECLARATION OF JERRY L. PHILLIPS

Pursuant to 28 U.S.C. § 1746, I, Jerry L. Phillips, declare the following:

1. I am the Undersecretary of the Louisiana Department of Health and Hospitals ("DHH"), which includes Louisiana's single State Medicaid agency.

2. As Undersecretary, I direct the Office of Management and Finance (OM&F). The OM&F manages DHH's budget and oversees the Louisiana Medicaid program, as well as the administrative divisions with departmental responsibilities for budget preparation, financial forecasting, research and planning, purchasing,

personnel, training, contracting, program evaluation, quality assurance, payment management, accounting, data processing, and strategic and operational planning. Additionally, I assist the Secretary and Deputy Secretary of the Department in the planning and execution of all major departmental efforts and initiatives.

3. Before becoming Undersecretary earlier this year, I worked in the Louisiana Medicaid program for ten years, first as Deputy Director and then as Director. Prior to that, I was a member of DHH's legal staff for eleven years, during which I worked closely with the Medicaid program.

4. I have personal knowledge of the Medicaid program in Louisiana and the impact of the Patient Protection and Affordable Care Act (the "Act") on Louisiana's Medicaid program.

5. The sections that follow provide further information on the Act's injurious impact on Louisiana Medicaid, and, if called to testify as a witness, I could explain that impact competently.

A. Louisiana's Medicaid Program Prior to the Act

1. Louisiana's Medicaid program began in 1966.

2. It is my understanding that when Louisiana entered into the Medicaid Program, the State understood it to be a state/federal partnership that allowed state flexibility and control over a variety of aspects of the program. This allowed states to specifically construct a Medicaid

Program that is (a) tailored to meet the needs of its citizenry and (b) within its budgetary means.

3. It is my understanding that Louisiana entered into the Medicaid Program with the expectation that the federal government's role in the program would be one of partnership with the States, not one of coercion. Louisiana fully anticipated that any expansions of Medicaid eligibility for particular coverage groups would remain optional at the discretion of the States, rather than being required by mandates from the federal government, so that the States would not be forced to expand eligibility for enrollment beyond their ability to fund their participation in the program.

4. Moreover, the Act has expanded the definition of "medical assistance" for Medicaid purposes to include, for the first time, the actual provision of health care services. Since the original definition encompassed only the payment for health care services, this represents a significant departure from Louisiana's previous understanding of what the States are required to do under the Medicaid Program.

B. The Act's Injurious Impact on the Federal-State Healthcare Partnership

1. The Act eliminates Louisiana's flexibility with respect to eligibility. The states used to have flexibility to carve a Medicaid program that the state felt was best suited to caring for its most vulnerable and still fell with state budgetary constraints. Defining eligibility was a key part of that flexibility that was completely eliminated

by the Act. Louisiana is now locked into a program that is covering over 102,000 childless adults, over 283,000 parents in an optional category and several other optional populations. Louisiana has exercised the option to allow persons with an institutional level of need to participate in the program up to 300 percent of the Federal Benefit Rate. It has also elected a parental income disregard for children with an institutional level of need. The State also provides coverage under the Breast and Cervical Cancer Treatment Program and the Medicaid Purchase Plan. These are examples of options the State has elected that now have become mandated. These are also examples of options, that during this major recession, the State simply cannot afford, but the Act has forced Louisiana to retain them in the program.

2. The Act essentially requires the State to make cost-saving adjustments to the Medicaid Program on the backs of its providers. Medicaid funding is a three-legged stool, in essence — eligibility, provider reimbursement and benefits. The Act prohibits states from adjusting eligibility. Thus, states can make changes to benefits and provider rates. Changes to benefits may save money in the short term but often are more costly in the longer term because managing a member's care is more effective than paying for emergency care. Meanwhile, the real dollar savings comes from reducing rates. Provider reimbursement is critical to maintaining access to care and an adequate provider network that will meet the needs of the

Medicaid members. The states cannot so damage their relationships with providers by reducing reimbursement to a point where providers are no longer willing to accept Medicaid patients. Providers should be reimbursed fairly and adequately for the care they provide. The Act disregards this issue and forces states to reduce provider rates.

3. The Act increases Medicaid rates for primary care physicians, and a substantial portion of that increase must be funded by the States. Louisiana estimates that this will increase its costs by approximately $186 million in State Matching Funds. In addition, the higher rates for primary care physicians may increase provider participation in the Medicaid program and broaden enrollee access to primary care services. A portion of the enrollee health care needs that are identified by primary care providers will require follow-up with specialty physician services, and increases in physician fees for those specialty services may be needed to meet related demand. This will likely cost Louisiana Medicaid an additional $38.5 million or more in State Matching Funds from 2014 to 2023.

4. Louisiana is currently undergoing review as to whether the State will operate its own Exchange. Regardless of the outcome of that policy decision, Louisiana Medicaid will have to upgrade its eligibility systems in order to be interoperable with the Exchange such that it can screen for Medicaid/CHIP. The State will also need to acquire resources and expert

staffing in order to address Exchange requirements relating to instituting regulations, consumer protections, rate reviews, solvency and reserve fund requirements, and premium taxes.

5. The expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level will increase Louisiana's costs, less so in the early years but more so after 2016. Louisiana estimates that the mandated expansion will result in the enrollment of approximately 617,000 parents and childless adults at a cost to the State of approximately $701 million in State Matching Funds from 2014 to 2023.

6. In addition, many of the individuals who are added to the Medicaid rolls as a result of this expansion will be children who are currently covered under Louisiana's Children's Health Insurance Program (LaCHIP). Because the Federal Medicaid Assistance Percentage (FMAP) rate for Medicaid is lower that the FMAP rate for LaCHIP, the federal government will pay a smaller share of the total cost of Medicaid services to children with household incomes between 101 and 133 percent of the federal poverty level, and consequently more State General Funds will be required to maintain coverage of this population. Louisiana estimates that this will cost it approximately $291 million in State Matching Funds from 2014 to 2023.

7. Louisiana anticipates that the Act's individual mandate to obtain health insurance coverage

will result in the Medicaid enrollment of more than 27,000 Louisiana parents with incomes below 11 percent of the federal poverty level who are currently eligible but unenrolled, at a cost to the State of approximately $701 million in State Matching Funds from 2014 to 2023.

8. The Act's requirement that Louisiana be responsible for providing healthcare services to Medicaid enrollees (as distinguished from providing healthcare funding) will almost certainly expose the State to increased costs and litigation risks. Neither the Medicaid Act nor state law gives the State Medicaid agency any authority to compel providers to render care to Medicaid patients. The only way to encourage provider participation is to raise payment rates, which is not feasible at this time.

C. The Act's Injurious Impact Louisiana

1. Based on U.S. Census Bureau statistics for 2008, Louisiana has more than 800,000 uninsured individuals living in the State. Of those, according to data contained in the DHH eligibility system, the U.S. Census Bureau Current Population Survey (CPS) data from 2004-2008, and the 2007 Louisiana Household Insurance Survey, there are more than 400,000 adults between the age of 19 and 64 whose income is below 133 percent of the federal poverty level, and therefore must be added to Louisiana's Medicaid rolls as required by the Act.

2. Medicaid outlays for Louisiana consume approximately 22 percent of the State's budget.

For FY 2009-2010, Louisiana spent nearly $7 billion (State Matching Funds) on Medicaid, servicing approximately 1.31 million persons.

3. It is now feasible for Louisiana to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid-like program. The Medicaid program accounts for nearly $7 billion (State Matching Funds) in health care spending annually for the State of Louisiana. Moreover, Louisiana Medicaid members are integrated within the overall Louisiana health care delivery system. That means that Medicaid members rely on the very same providers from whom all Louisianans receive care. Eliminating Medicaid would mean that hospital uncompensated care would skyrocket, hospitals would have to close certain departments, stop expansion projects, and physicians would see a loss in revenue. In addition, community health centers would see a severe decline in their insured patient mix. The hit to Louisiana's health care system would be devastating.

4. The added costs to Louisiana under the Act would not be offset by increased federal contributions under the Act. In fact, Louisiana believes that overall, the Act will potentially cost the State approximately an additional $7 billion in State Matching funds from 2010 to 2023.

5. DHH estimates that more than 233,000 parents, children and childless adults with incomes up to 133 percent of the federal poverty level who are now covered by employer sponsored health

insurance will drop that coverage and enroll in Medicaid, at a cost to the State of approximately $1.2 billion in State Matching Funds from 2014 to 2023.

6. The health care system as a whole is financed by a mix of public and private payer sources. Public programs, such as Medicare and Medicaid, often compensate health care providers below the cost of service while private insurers compensate at or above cost. In effect, private health insurance payments underwrite the cost of uncompensated care resulting from public program payments. To offset uncompensated costs, some hospitals received Disproportionate Share (DSH) payments. Medicaid DSH payments pay for either the difference between Medicaid rates and actual cost ("Medicaid shortfall") and/or the actual cost of care to the uninsured. With the expansion of Medicaid to adults with income below 133 percent of the federal poverty level, the health care system as a whole will depend more on the Medicaid program as a payer source at the same time as DSH allocations, including those that pay for the Medicaid shortfall, to states are reduced. The result may be an increase in uncompensated cost for hospital services provided to Medicaid enrollees. Assuming that Medicaid rates for inpatient and outpatient hospital services will have to increase to 90 percent of cost to prevent or moderate increases in hospital uncompensated cost from Medicaid shortfall, Louisiana estimates that this will cost it approximately $1.8 billion in State Matching Funds.

7. One of the most difficult aspects of the Act is allocating scarce resources in order to implement the Act's requirements. There are numerous provisions directly impacting the Medicaid program. Then there are a variety of other provisions that will require action on the part of State Medicaid programs, like the Exchange. The Louisiana Medicaid Administration has made reductions and streamlined administrative functions wherever possible. Currently, all staff is focused on only critical core Medicaid functions. The Act has disrupted this focus and mandated how the State allocates scare resources. Almost overnight, Louisiana Medicaid has had to devote funds and human resources to implement changes such as enforcing immediately-effective provisions of the Act; determining gaps between current State resources and resources that are projected to be needed to comply with the Act; evaluating current State infrastructure to determine how to implement new programs and to expand existing programs to comply with the Act; developing a strategic plan and coordinating the plan across various affected State agencies; initiating legislative and regulatory processes to comply with the Act; being familiar and dealing with federal regulatory processes to protect State interests; deciding whether to participate in optional programs under the Act; developing communications to disseminate information regarding changes brought about by the Act to affected persons or entities in Louisiana. In fact,

the State has been required to add an entire new section to its Medicaid staff which is dedicated solely to ensure compliance with the Act, at an annual cost of almost $750,000 in State Fiscal year 2011 alone.

8. These added costs under the Act will have a significant effect on Louisiana's fiscal condition, decreasing its discretion to fund other critical needs such as education, corrections, law enforcement and more.

D. Louisiana Cannot Avoid the Act's Requirements and Effects

1. If Louisiana terminates its participation in Medicaid, 1.31 million of its most vulnerable citizens would be left without access to the healthcare services they have depended on for years under the Louisiana Medicaid program. Such an occurrence is unfathomable.

2. As partly noted above, ending Louisiana's participation in Medicaid would devastate the overall health care system upon which all Louisianans rely. Medicaid funding has been a significant part of Louisiana's hospitals' ability to gain a payor source for what was previously uncompensated care. Louisiana's safety net hospitals would be completely devastated and would have to shut down beds and close down entire areas. Community Health Centers would also be hurt by the elimination of Medicaid. Since they serve as a critical safety net, having Medicaid as a payor is tremendously important. There also are so many Louisiana physicians who are dedicated to caring for Louisiana's most

vulnerable citizens. These physicians would not be able to continue their mission without Medicaid as a payor. Of particular concern would be the impact to nursing facilities, intermediate care facilities for the developmentally disabled, home and community based services providers and behavioral health providers, all of whom are largely dependent on Medicaid. Finally, the impact to ancillary services, such as labs, transportation companies, etc., that support the health care community cannot be underestimated. These are important businesses in Louisiana. Combined, the termination of Medicaid would not only harm health care but impact the State's economy and increase job losses.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information and belief.

Executed this 10th day of September, 2010, at Baton Rouge, Louisiana.

_____

Jerry L. Phillips
Undersecretary, Louisiana Department of Health and Hospitals
628 N. Fourth St.
Baton Rouge, Louisiana 70802

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-4

AFFIDAVIT OF MAGGIE ANDERSON

STATE OF NORTH DAKOTA
COUNTY OF BURLEIGH

Maggie Anderson states as follows:

1. I swear and affirm under penalty of perjury that the statements made in this affidavit are true and correct.

2. I am the Director of the Medical Services Division of the North Dakota Department of Human Services (NDDHS), which manages and oversees the North Dakota Medicaid program. My duties consist of directing the operations of the Medicaid, Children's Health Insurance, and

state-funded Home and Community-Based Services Programs.

3. The Patient Protection and Affordable Care Act restricts North Dakota's ability to define health care eligibility and attributes under North Dakota's Medicaid Program to a degree that significantly limits North Dakota's discretionary authority.

4. Based on 2008 Census Bureau statistics (Current Population Survey: Health Insurance Coverage Status by State for All People: 2008), North Dakota has approximately 74,000 uninsured persons living in the state. As of July 2010, the North Dakota Medicaid enrollment was 62,486. According to projections from the Kaiser Commission on Medicaid and the Uninsured, due to the Patient Protection and Affordable Care Act, the enrollment in the North Dakota Medicaid program could increase by 44% by 2019. *See* Ex. A at 10.

5. Medicaid outlays for North Dakota consume 12.6% of North Dakota's 2009-2011 state budget. These outlays come from the State's general fund. For State Fiscal Years 2010 and 2011, North Dakota estimates spending $408.7 million of state general funds on Medicaid. For State Fiscal Year 2009, the unduplicated count of Medicaid recipients was 77,637.

6. In my view, as Director of the state's Medicaid program, it would not be feasible for North Dakota to operate a traditional Medicaid-like program in the absence of federal funding.

7. The added costs to North Dakota under the Patient Protection and Affordable Care Act would not be offset by increased federal contributions under the Act. *See* Ex. B. Over the next 10 years it is estimated the net additional state Medicaid expenditures (state general funds) required under the Act will exceed $105 million. *See id*. at 1.

8. North Dakota, through the NDDHS Medical Services Division, the state's designated Medicaid agency, estimates some individuals who now have some form of health care insurance but fall below 133% of the federal poverty level will drop their coverage and enroll in Medicaid. Based on estimates from the US Census Bureau (Current Population Survey Annual Social and Economic Supplement (2006-2009)), there are approximately 27,679 individuals at or below 133% of the poverty level in North Dakota between the ages of 21 and 64 with insurance. If 33% of the 27,679 drop their insurance and enroll in Medicaid in 2014, it is estimated it will cost the state of North Dakota $11.1 million (based on estimated costs from the Lewin Group report, October 2009) for the period of 2014 through 2019. *See* Ex. C at 6. If 50% of the 27,679 drop their insurance and enroll in Medicaid in 2014, it is estimated it will cost the state of North Dakota $13.9 million (based on estimated costs from the Lewin Group report, October 2009) for the period of 2014 through 2019. *Id.*

9. The Patient Protection and Affordable Care Act requires that NDDHS immediately begin to

devote funds and human resources to implement changes necessary to comply with the Act.

10. Exhibit B contains assessments and projections relating to particular aspects of the Patient Protection and Affordable Care Act and the Act's impact on North Dakota's Medicaid program. Each layer of information within the exhibit has been collected, analyzed, and reported by agency personnel having knowledge, expertise, and experience for performing such tasks.

11. Exhibit B was prepared by Affiant with the assistance of Brenda Weisz, Chief Financial Officer of the NDDHS, immediately prior to the May 27, 2010 Legislative hearing at which it was presented. We regularly prepare reports on Medicaid expenditures. *See, e.g.*, NDDHS 2007-2009 Biennial Report (Nov. 2009), available at www.nd.gov/dhs/info/pubs/docs/2007-2009-dhs-biennialreport.pdf.

12. Exhibit B was not created in anticipation of litigation, but pursuant to statutory requirements or authorizations. Under N.D.C.C. § 54-06-04, NDDHS is required to prepare a biennial report that includes a detailed review of Medicaid expenditures. NDDHS regularly reviews and develops recommendations regarding various healthcare services provided to Medicaid recipients similar to the assessments and projections set forth in Exhibit B.

13. I certify that Exhibit B is an official public record. Exhibit A is a market report that contains published compilations of Medicaid

enrollment and expenditures and projections of enrollment and expenditures generally used and relied upon by the public and government officials responsible for Medicaid programs.

14. The assessments and projections stated in this Affidavit are complete and accurate to the best of Affiant's knowledge as of the date of this Affidavit, and are subject to revision (a) as additional data is generated over time, (b) as the Patient Protection and Affordable Care Act is amended or as regulations pursuant to the Act are announced and implemented by federal agencies, and (c) as NDDHS receives policy guidance from the Centers for Medicare and Medicaid Services.

15. The furnishing of the official statements in this Affidavit and in Exhibit B is within Affiant's official duty.

16. Attached as Exhibit A is a true and correct copy of Appendix F to the May 27, 2010 Minutes of the Industry Business and Labor Interim Committee, Kaiser Commission on Medicaid and the Uninsured, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL [federal poverty level], Urban Institute, May 2010, attached to NDDHS/Anderson testimony, May 27, 2010 interim committee hearing; and attached as Exhibit B is a true and correct copy of Appendix E to the May 27, 2010 Minutes of the Industry Business and Labor Interim Committee, NDDHS White House/Congressional Leadership Reconciliation

Bill Preliminary Estimate of Health Care Reform Impacts on ND Medicaid May 27, 2010, and attached as Exhibit C is a true and correct copy of the Memorandum from John Sheils and Randy Haught of The Lewin Group, to the National Governors Association on Cost and Coverage Estimates for the Medicaid Expansion Provision of the Senate Finance Health Reform Proposal in North Dakota (Oct. 5, 2009).

Dated this 11th day of October, 2010.

_____

Maggie Anderson

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-4

AFFIDAVIT OF VIVIANNE M. CHAUMONT

I, Vivianne M. Chaumont, being first duly sworn, hereby depose and state as follows:

1. I am competent to testify to the matters in this Affidavit.

2. This Affidavit is based on my personal knowledge and is offered in support of Plaintiffs' Motion for Summary Judgment.

3. I am the Director of the Division of Medicaid and Long-Term Care for the Nebraska Department of Health and Human Services (Nebraska DHHS). My responsibilities include the administration of the Medicaid program which is subject to requirements of state and

federal regulatory and statutory authority. Neb. Rev. Stat. § 68-904 to 956; Titles XIX, 42 USC §1396a, *et seq*.

4. The Nebraska Medicaid program is a medical assistance program, created under Title XIX of the federal Social Security Act, for individuals who fit within federally defined eligibility categories.

5. Nebraska statute requires that the State of Nebraska accept and assent to all applicable provisions of Title XIX of the federal Social Security Act. Neb. Rev. Stat. § 68-906.

6. The State of Nebraska is required to have a State Plan, which is reviewed and approved by the federal Department of Health & Human Services Centers for Medicare and Medicaid Services (CMS). The Medicaid State Plan is the "comprehensive written document, developed and amended by [Nebraska DHHS] and approved by CMS, which describes the nature and scope of the medical assistance program and provides assurances that [Nebraska DHHS] will administer the program in compliance with federal requirements." Neb. Rev. Stat. 68-907(4).

7. As Medicaid Director, I am required to ensure that the Medicaid program is administered in compliance with federal law.

8. In order to receive federal financial participation (FFP), the State of Nebraska must comply with all federal requirements of the Medicaid program. FFP accounts for nearly 60% of the

funds which pay for the Medicaid program, and amounts to over $1 billion annually.

9. As Director, I am generally aware of changes in federal law, including the Patient Protection and Affordable Care Act, PL 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, PL 111-152 (hereinafter, the Act) and it is part of my duties to consider what impact changes in federal law may have on Nebraska's Medicaid program.

10. Because the Act would add large new populations to Nebraska's Medicaid program, Nebraska DHHS retained the services of Milliman, Inc., an actuarial firm, to review the Act and submit a written analysis of the impact of that Act as it pertains to DHHS and the State's Medicaid program.

11. Milliman conducted its review and analysis and provided a report to Nebraska DHHS, a true and correct copy of which is attached and marked as Exhibit A.

12. Nebraska passed legislation to implement the Medicaid program in 1965.

13. The original Nebraska Medicaid program was established under the premise that Nebraska would be required to cover specified limited populations, including needy children and their caretaker relatives, needy disabled and needy elderly.

14. Prior to the Act, expansion of eligibles has been at the discretion of the State of Nebraska, taking into account state resources. The Act, which

would greatly expand eligibility beyond that originally contemplated by the Medicaid statute, regardless of the availability of state resources, was not contemplated.

15. The State of Nebraska has had the flexibility to stop coverage of any category of eligibles that was not mandatory. The Act takes that flexibility away from Nebraska. Not only is the federal government adding large new populations, it is restricting the state's ability to manage its resources by not allowing Nebraska to drop optional coverage of eligibles.

16. In addition, the State of Nebraska's discretion to change eligibility criteria has been taken away, as well as the State's ability to increase or implement new premiums and other tools needed to manage resources.

17. The Act increases rebate percentages for covered outpatient drugs provided to Medicaid clients. However, the Act provides that the impact of these increased rebate percentages will accrue to the federal government. The Milliman report estimates that this could reduce Nebraska's drug rebates between 20.7% to 22.6% beginning in January 2010, for a total negative impact of between $68.1 and $74.4 million dollars from state fiscal years 2011 through 2020. Please see Exhibit A.

18. The expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 138% (based on the 5% disregard in the statute) of the federal poverty level will increase the State of Nebraska's share of expenses relating to

Medicaid, with the costs increasing on an accelerated basis after 2016.

19. Prior to the Act, the statute and case law have been clear that states have to pay for services, but are not responsible for providing services. The Act's requirement that Nebraska be responsible for providing health care services to Medicaid enrollees is an expansion of Nebraska's responsibility, which could easily add to litigation against the State by leading to inc1 ·eased costs and litigation risks.

20. Based on 2008 census bureau statistics, the State of Nebraska has 210,674 uninsured persons living in the state. Of those, 85,031 are below 138% of the federal poverty level and must be added to the State of Nebraska's Medicaid rolls under the Act.

21. Medicaid outlays for the State of Nebraska consume 19% of the state's budget. For fiscal year 2009·2010, Nebraska spent approximately $1.5 billion dollars in total funds on Medicaid, servicing approximately 201,000 persons.

22. It would not be feasible for the State of Nebraska to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid -like program prior to the Act taking effect.

23. The added cost to the State of Nebraska under the Act will not be offset by increased federal contributions under the Act.

24. The State of Nebraska estimated that 50 to 100% of persons who now have some form of

health care insurance but fall below 138% of the federal poverty level will drop their coverage and enroll in Medicaid. These persons represent a significant cost to the State of Nebraska.

25. In order to implement the Act in 2014, there are numerous administrative changes, including system changes, which need to take place prior to 2014. No additional administrative funding has been provided to the states at a time when state resources, including the State of Nebraska's resources, are shrinking. The Milliman report estimates administrative costs at $82.4 to $106.8 million dollars for state fiscal years 2011 through 2020. Please see Exhibit A.

26. The State of Nebraska established the Medicaid program by adopting a statute authorizing establishment of the program. State legislation would be required to cease the program.

Further affiant sayeth not.

_____

Vivianne M. Chaumont
Director, Division of Medicaid
and Long Term Care
Department of Health and
Human Services

Subscribed and sworn to before me this 14th day of September, 2010.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-5

DECLARATION OF JAMES R. WELLS

Pursuant to 28 U.S.C. § 1746, I James R. Wells, declare the following:

1. I am a resident of the State of Nevada and I make the statements in this declaration based upon my personal knowledge and upon the books and records of the Nevada Public Employees' Benefits Program (PEBP).

2. I am the Executive Officer of PEBP and I am responsible for employee benefit administration for the State of Nevada. I have held this position since June 2010.

3. PEBP is created and governed by Nevada Revised Statutes (NRS) chapter 287 and the

adopted regulations in Nevada Administrative Code (NAC) chapter 287.

4. PEBP administers the health, dental, vision, life, long-term disability and flexible spending account insurance programs for all eligible State employees, the employees of local government entities who have chosen to participate in the PEBP insurance programs pursuant to NRS 287.025, State retirees who have chosen to participate in one of the benefit plans offered by PEBP, local government retirees whose employers have contracted with PEBP pursuant to NRS 287.025 who have chosen to participate in one of the benefit plans offered by PEBP and local government retirees whose employers have not contracted with PEBP pursuant to NRS 287.025 but who were enrolled in the program on November 30, 2008. PEBP also provides assistance to participants (employees, retirees and their dependents) with questions regarding eligibility, access to services and claims, including a claim appeal process.

5. PEBP operates on a July 1 to June 30 plan year.

6. PEBP offers a selection of comprehensive benefit programs to all State employees, retirees and public officers as well as to the employees, retirees and public officers of local government organizations who contract with PEBP for health care pursuant to NRS 287.025. PEBP offers both fully insured Health Maintenance Organization (HMO) options and a self-insured group medical insurance option. The dental benefit is self-insured for all participants. The

administration and funding of the State's benefit programs is through the Fund for the Public Employees' Benefit Program (NRS 287.0435).

7. Federal health care reform, formally known as the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA), requires PEBP to amend its Plan and offer PPACA prescribed benefits to participants, including:

    a. removal of any lifetime and annual policy limit provisions (ACA § 1001 (PHSA § 2711)) effective with the plan year beginning July 1, 2011;

    b. extending dependent coverage to age 26 (ACA § 1001 (PHSA § 2714)) effective with the plan year beginning July 1, 2011; and

    c. reporting requirements (ACA § 1001 (PHSA § 2718)) effective with the plan year beginning July 1, 2011.

8. As a result of PPACA's requirements that additional benefits be given to officers and employees in PEBP's Plan, increased costs will be imposed on PEBP.

9. PPACA's requirement that PEBP expand dependent coverage to age 26 has a projected impact between $4,000,000 and $6,100,000 for the plan year July 1, 2011 to June 30, 2012 and a projected impact between $4,250,000 and $6,440,000 for the plan year July 1, 2012 to June 30, 2013.

10. PPACA's requirement that PEBP remove lifetime and annual policy limits has a projected

impact between $1,250,000 and $2,000,000 for the plan year July 1, 2011 to June 30, 2012 and a projected impact between $1,290,000 and $2,140,000 for the plan year July 1, 2012 to June 30, 2013.

11. The projections stated herein are complete and accurate to the best of PEBP's knowledge as of the date of this Declaration, and are subject to revision (a) as additional data are generated over time and (b) as the PPACA is amended or as regulations pursuant to the PPACA are announced and implemented by federal agencies.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 3rd day of September, 2010.

James R. Wells, Executive Officer
Public Employees Benefits Program

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-5

DECLARATION OF MICHAEL J. WILLDEN

Pursuant to 28 U.S.C. § 1746, I, Michael J. Willden, declare the following:

1. I am the Director of the Nevada Department of Health and Human Services (DHHS). DHHS is the "umbrella organization" for Nevada's health care programs, including Medicaid and the Nevada Check-Up (CHIP) program.

2. I have been the Director of DHHS for over nine years and worked within the Department for over thirty-five years in many roles.

3. I have personal knowledge of the Medicaid and Check-up programs in Nevada and the impact of

the Patient Protection and Affordable Care Act (PPACA) on these programs.

4. The sections that follow provide information on the Act's impact on DHHS in Nevada, most noticeably the Medicaid program, and if called to testify as a witness, I could explain that impact.

Medicaid Program Prior to the Act

1. The Nevada Medicaid program started in 1967.

2. Throughout the history of Nevada Medicaid, there has been an understanding that the federal/state partnership allowed for flexibility and state discretionary control in designing and administering the program. Restrictions of state discretionary authority have occurred in the past. However, the Act did significantly limit State discretionary authority more so than in the past by imposing Maintenance of Eligibility requirements limiting the State's ability to manage its Medicaid and CHIP programs within severe revenue and budget constraints.

3. Nevada's Medicaid program has experienced numerous federally mandated eligibility expansions from the outset. The program initially started funding medical care for the poor receiving welfare payments, primarily single parents with dependent children and aged, blind and disabled individuals. Federal legislation in the 1980 and 1990s expanded Medicaid eligibility beyond traditional welfare populations. However, the Act is expanding Medicaid eligibility requirements to

unprecedented levels. While much of this expansion will initially be fully federally funded through 2016 for those made newly eligible through the Act, it is the State's belief that many more enrollees will obtain Medicaid coverage under current eligibility standards, imposing a significant cost burden on the State. Additionally, the new administrative expense associated with this expansion is significant. The State estimates that between 2013 and 2019 the Act will incrementally cost the State more than $574 million in state general funds. (See attached "Health Care Reform projected cost.")

4. Nevada has always understood the Medicaid program to be a "vendor payment" program; reimbursing health care professionals and entities for services provided to eligible recipients. The provision of the Act to "provide medical services" is a serious concern; as yet it is unclear what the impact of this may be.

5. Nevada has historically maintained stringent eligibility requirements for its Medicaid program, however, limiting access to the program only to those most in need. The significant expansion of eligibility under the Act departs from the historical use of Medicaid in Nevada.

The Act's Injurious Impact on the Federal-State Healthcare Partnership

1. The Act restricts Nevada's ability to revise Medicaid eligibility in order to administer the program under state budgetary constraints. The

Maintenance of Eligibility requirements of the Act takes away one of the most effective cost-savings techniques available to manage the Medicaid program.

2. The Act limits Nevada's ability to operate the Medicaid program within budget constraints through Maintenance of Eligibility provisions. This instead requires the State to reduce provider payments, and reduce or eliminate essential services. Reductions in provider rates not only affect access to care for recipients, but also lead to cost-shifting to other payers and patients by provider. These changes are necessary for Nevada to continue to operate its Medicaid program, but may have the long-term effect of increasing costs due to delays in access to services that result in avoidable hospital admissions and emergency room services.

3. The Act requires the State to pay primary care physicians the Medicare rates in effect 2013 and 2014. There will be 100% federal financing during this time based on Medicare rates in effect in 2009. The State will need to decide whether it will continue paying physicians at that level or to lower the rates after 2014. Assuming the State continues to pay primary care physicians at the Medicare level, the estimated cost between 2013 and 2019 is approximately $28.8 million in state general funds.

4. The Act changes how Medicaid drug rebates are calculated and shared with the federal government. The Act increases the minimum

federal drug rebates for fee for service Medicaid program increase from 15.1 to 23.1 percent of the average manufacturer price. Nevada estimates that the increase in the minimum drug rebate percentage will save approximately $881,000 in state fiscal year 2012. However, this increase may be partially offset by the need to increase payments to managed care plans for their loss of discounts and rebates also associated with the Act.

5. The Act expands Medicaid eligibility for individuals under age 65 with incomes up to 138 percent of the federal poverty level. Nevada estimates that between 2013 and 2019 the Act will incrementally cost the State more than $574 million in state general funds. (See attached "Health Care Reform projected cost.")

6. The Acts requirement that Nevada be responsible for providing healthcare services to Medicaid enrollees, as distinguished from paying providers for health care services, is a serious concern. However, until the full scope of the language of the Act cannot be assessed until regulations are promulgated by the Centers for Medicare and Medicaid Services (CMS).

The Act's Injurious Impact on Your State

1. Based on the 2008 Census Bureau statistics, Nevada had 486,000 uninsured people living here. Of those, an estimated 155,500 are below 133 percent of the federal poverty line and must be added to Nevada's Medicaid rolls under the act.

2. Medicaid outlays for Nevada consume more than 15% of the state budget. For the fiscal year that ended June 30, 2010, Nevada was budgeted to spend nearly $385 million in state general funds on Medicaid programs, servicing approximately 221,235 people.

3. Nevada estimates that by 2019, more than 56,000 currently eligible non-recipients of Medicaid will enroll in the program because of the Act's requirement for individuals to have insurance coverage. The estimated cost to provide medical benefits to this group between 2014 and 2019 is $348 million in state general funds. This estimate is based on the understanding that federal financial participation for this group of eligible recipients will be at the regular Federal Medical Assistance Percentage (FMAP), which for purposes of this calculation was assumed to be 50.00%. (See attached "Health Care Reform projected cost.")

4. Current estimates are that between 2013 and 2019, the State will need an additional $574 million in state general funds to cover the cost of the Act's Medicaid expansion. Although that estimate includes about $35 million for a replacement of the state's current eligibility system to handle increased caseload due to reform. However, this estimate does not include potential costs associated with building a health insurance exchange, or other related information technology costs. (See attached "Health Care Reform projected cost.")

5. Nevada has evaluated the potential effects of opting out of the Medicaid program entirely. The issues and impacts are included in a white paper (attached) entitled "Medicaid Opt Out." Nevada feels that the affects of ending its Medicaid program would be extremely harmful to recipients and providers, and would have wide-ranging affects on state and local government entities, schools, hospitals and safety net programs. It is estimated that almost 200,000 Nevada residents would lose medical coverage. Nor would they be eligible for subsidizes health insurance exchange coverage provided in the Act. Critical long term care services for the elderly, disabled, as well as services for individuals with mental retardation and developmental disabilities would no longer be funded. Nursing facilities, with a high percentage of Medicaid patients making up their census, would be at risk of closure due to the loss of Medicaid revenue. Access to essential acute medical services, like physician and hospital services, would no longer be funded for these individuals, putting those with chronic medical conditions at serious risk. Community based supports and services that keep people out of institutions would not be available and likely would not be paid for through health insurance exchange plans, leading to unnecessary placements in nursing facilities and group homes. Eliminating Nevada Medicaid would also impact state and local government agency funding by eliminating federal Medicaid dollars as a source of revenue. This would affect adult

and children's mental health services, as well as services provided by county agencies and schools. Local government agencies would also see a significant reduction in federal revenues which would challenge their missions to serve the general public. Finally, supplemental payments to safety net hospitals would cease putting programs and services that provide essential community benefits at risk, such as HIV and AIDS clinics and clinics for high risk pregnant women. After considering these impacts, Nevada has determined that is cannot opt out of this essential program.

6. The added costs to Nevada associated with the Act will have a significant effect on the State's fiscal condition, beyond those it is currently experiencing. As demonstrated above, the incremental costs to Nevada associated with implementation of the Medicaid provisions of the Act are not offset by the federal funding support included the Act.

7. The Act's provisions also provide an opportunity for small businesses to consider dropping their current employer based insurance and allowing their employees to elect coverage through the health insurance exchange. Many of these employees are low-wage workers and will likely be eligible for expanded Medicaid coverage below 138% of the federal poverty level. We estimate that as many as 40,000 individuals previously covered through their employer may instead get their coverage through Nevada Medicaid.

8. To fund these incremental costs associated with the Medicaid provisions of the Act, Nevada will inevitably need to reduce spending in other essential areas that the State is already struggling to fund, including K-12 education, prisons, law enforcement and its universities and community colleges.

9. The Act includes timeframes that require Nevada begin spending funds to plan and implement a number of changes to the Medicaid program this fiscal year. The State has hired two dedicated staff to work solely on managing the Medicaid and Children's Health Insurance Program (CHIP) provisions of the Act. We have already engaged a consulting firm to help us with planning for numerous aspects of the Act. The largest component of these plans includes the development of a new electronic eligibility system that will be essential for determining Medicaid and CHIP eligibility. Legislative Interim Finance Committee contingency funding totaling $279,118 was requested and provided to support the initial planning effects. Also to date Nevada has tracked 6522 planning hours by staff at a cost of $257,101. (Cost summary and memo attached.)

10. Nevada DHHS engaged the consulting firm Public Consulting Group (PCG) to assist us in planning to implement a Health Insurance Exchange and to develop a new electronic eligibility system to interface Medicaid/CHIP with an exchange. PCGs estimated costs for the "eligibility engine" was $23,849,037. Ongoing

annual costs are estimated at $3,765,163. (PCG Study attached.)

Your State Cannot Avoid the Act's Requirements and Effects

1. The Act provides subsidies and credits for individuals between 100% and 400% of the federal poverty who obtain qualified coverage through the health insurance exchange. However, individuals below 100% of the federal poverty level are not eligible for subsidized coverage. Hence, should Nevada be forced to consider opting out of Medicaid, these individuals may find that health coverage is unaffordable and hence unavailable.
2. It is our current belief that the Act does not revise provisions of the Social Security Act that deal provide the option for the State to participate in the Medicaid program. As such, Nevada can still consider opting out of Medicaid a viable option. However, given the concerns outlined in the white paper, "Medicaid Opt Out," it is unlikely the State will chose to end its Medicaid program.

I declare under penalty of perjury that the foregoing is true and correct based on the information available to the Division.

Dated this 3rd day of September.

_____

MICHAEL J. WILLDEN
DIRECTOR, DEPARTMENT OF
HEALTH AND HUMAN SERVICES

AFFIDAVIT OF STEVEN R. VAN CAMP

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

PERSONALLY APPEARED before me, Stephen R. Van Camp, who being duly sworn, attests to the following:

1. He is the Director of the State of South Carolina's Employee Insurance Program, which administers the Group Health Benefits Plan of the Employees of the State of South Carolina, the public school districts, and participating entities (typically referenced as the "State Health Plan").

2. He is familiar with the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (ACA).

3. State Health Plan participants include state officers as well as employees of:

   - State agencies (pursuant to S.C. Code Ann. § 1-11-710)
   - Public school districts (pursuant to § 1-11-710)
   - Other participating entities/local subdivisions that elect to participate pursuant to § 1-11-720

   Participants also include retirees of these employers as defined in § 1-11-730 and the eligible spouses and eligible children of employees and retirees.

4. On January 1, 2011, the State Health Plan will comply with the following ACA-prescribed benefits that were not previously provided under the Plan:

    - No preexisting condition exclusion for individuals younger than 19
    - No lifetime limits on essential benefits
    - Restricted annual limits on essential benefits
    - Prohibition on rescission of coverage
    - Dependent coverage of children younger than 26 (Prior to 2014, the State Health Plan will require that the child is not eligible for other employer-sponsored group health plan.)

5. The ACA's immediate requirement that additional benefits be given to officers and employees under the State Health Plan will require an increase in budgeted contributions from the State of $19.34 million for plan year 2011 (January 1 to December 31).

6. The State Health Plan has "grandfather status" at least through 2011. If this status is lost due to the State's failure to adhere to requirements of the ACA, such as not increasing the co-insurance or co-payment costs, then the State would incur substantial additional costs under the ACA of $60-70 million a year. If the State adheres to the ACA's prohibition on making changes in the State Health Plan, then the State could incur substantial additional costs of

funding the existing plan. These costs cannot be estimated at this time.

7. If the State were penalized in the future for not offering coverage to all full-time employees, the penalty would at least be $2,000 times the total number of employees of State agencies and public school districts. State agency and public school district employment now is approximately 120,000. Therefore, any such penalty could be as much as $240,000,000. Should the penalty be applied to local subdivisions and other entities that elect to participate pursuant to § 1-11-720, the penalty amount would greatly exceed this sum.

8. Should the State continue to offer the State Health Plan for employees of State agencies and public school districts in the future, and one or more of said employees chooses to enroll in a federally subsidized plan from an exchange instead of the State Health Plan, the penalty to the State would be $3,000 for each such employee enrolled in an exchange. Such penalty would not exceed $240,000,000. The number of employees who might enroll in such an exchange is speculative at this time.

9. The intention of this affidavit is to estimate costs and possible penalties that could be incurred by the State in the future under the ACA. The costs and possible penalties are projections now because regulations are still being developed. The State does not waive any claims or defenses that it might have now or in the future as to any penalty or attempted

application of ACA provisions to the State or its Health Plan including, but not limited to, the above matters.

_____

SWORN TO before me this 28th day of September, 2010

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-5

DECLARATION OF DEBORAH K. BOWMAN

Pursuant to 28 U.S.C. § 1746, I, Deborah K. Bowman, declare the following:

1. I am the Secretary of the South Dakota Department of Social Services and have acted in that capacity since my initial appointment on April 5, 2005. As Secretary, I am charged with overseeing the activities of the South Dakota Department of Socials Services (DSS).

2. This Declaration is based upon personal knowledge, information received from my staff based upon their personal knowledge and records maintained by DSS.

3. DSS's statutory duties and responsibilities are many. One duty is to administer South Dakota's Medicaid Program. DSS has been designated by the Governor as the state Medicaid agency for South Dakota.

4. South Dakota began participating in the Medicaid Program in 1967. Neither I nor my staff have personal knowledge, and DSS maintains no records, regarding South Dakota's expectations at the outset of its participation in the Medicaid Program.

5. Over the years, South Dakota's Medicaid Program has grown, as well as the cost to operate the program. In 1987, there were roughly 36,000 individuals enrolled in the Medicaid Program. Today, on a monthly average, there are roughly 101,000 enrolled individuals. These numbers do not include those individuals covered by the Children's Health Insurance Program (CHIP).

6. South Dakota's financial responsibility percentages for Medicaid Program benefit expenditures for recent federal fiscal years are:

FFY 02 - 34.07%
FFY 03 - 34.71%
FFY 04 - 34.33%
FFY 05 - 33.97%
FFY 06 - 34.93%
FFY 07 - 37.08%
FFY 08 - 39.97%
FFY 09 - 37.45%
FFY 10 - 37.28%
FFY 11 - 38.75%

For federal fiscal year 2010, this percentage was reduced to 29.20%, due to South Dakota's receipt of federal stimulus outlays under the American Recovery and Reinvestment Act (ARRA). The cost share percentage will rise in federal fiscal year 2011 to 31.08%. It is anticipated for fiscal year 2012, except for payment increases specified under the Patient Protection Affordable Care Act (PPACA), that South Dakota's cost share percentage will be 40.87%.

7. Despite South Dakota's relatively low cost share percentage, state funded Medicaid Program expenditures constitute the second largest expenditure of state general funds following education. South Dakota's share of Medicaid Program costs for fiscal year 2011 constitutes 22.93% of the general fund budget ($266,308,429.00 of the total general fund budget of $1,160,406,651.00). It is anticipated that during fiscal year 2011, over 141,000 persons will be served under South Dakota's Medicaid Program.

8. I have been asked to estimate the immediate fiscal impact that the PPACA will have on South Dakota's Medicaid Program. The estimates set forth below are complete and accurate to the best of my current knowledge and information as of the date of this Declaration.

9. The PPACA has required DSS to immediately devote substantial funds, resources and personnel to implement the required Medicaid Program changes. Implementation of PPACA will tax DSS resources and will require

additional state expenditures for associated costs. It is not possible to estimate the amount DSS will spend annually for state fiscal years 2011 through 2014 in money, resources and staff time to implement and comply with PPACA provisions. Lack of guidance from the federal government on the effect PPACA will have on the South Dakota Medicaid Program is a major factor in the ability to estimate.

10. The PPACA will have a significant long term impact on South Dakota's Medicaid Program. The number of individuals eligible for Medicaid will significantly increase. South Dakota will be required to expend additional state funds to provide Medicaid benefits to these individuals and pay increased administrative costs to comply with PPACA required changes.

11. The PPACA also reduces South Dakota's flexibility to manage the ever increasing costs of its Medicaid Program. The Act's provisions significantly restrict South Dakota's ability to reduce services, reimbursement rates and eligibility qualifications.

12. PPACA § 2301 changes the definition of medical assistance and requires South Dakota to provide medical services, as distinguished from providing payment for medical services. The prior definition was the basis for Medicaid Program payments prior to the PPACA. This definitional change may significantly alter South Dakota's Medicaid Program. To date, the Department of Health and Human Services has provided no guidance on whether or how the

definitional change of medical assistance affects South Dakota's Medicaid Program. In operating its Medicaid Program, South Dakota has relied heavily on the prior definition to provide the same payments for the same service regardless of provider or locality. This may not be the case under the new definition and a wave of litigation to determine the affect of this new definition is likely. In addition to litigation costs, the outcome of this litigation may significantly effect South Dakota's administration of this Medicaid Program as well as dramatically increasing program costs.

13. It is estimated that as a result of PPACA South Dakota's Medicaid average monthly enrollment will increase from approximately 101,000 to 155,100 individuals. Based upon 2008 Census Bureau Statistics, South Dakota has 98,000 uninsured residents. Of those, it is estimated that 48,000 are below 133% of the federal poverty line. With the 5% income disregard mandated by federal requirements, DSS estimates that an additional 49,600 individuals will be added to the South Dakota's Medicaid Program. It is also estimated that an additional 4,500 persons, who currently are eligible for Medicaid but have not enrolled, will enroll and obtain benefits, a result of the various PPACA insurance provisions going into effect, such as the PPACA's individual mandate. As to this latter category of individuals, South Dakota will have to pay its traditional Medicaid cost share, as the PPACA does not contemplate additional federal funds covering these expenditures.

14. DSS estimates that the increased costs to South Dakota associated with the projected Medicaid Program enrollment increases will be $62,600,000 from 2010 through 2019 and $36,000,000 annually thereafter. This estimate does not take into account any inflationary increases, increased provider payments and additional administrative costs.

15. Implementation of the PPACA's Medicaid Program provisions will increase state expenditures necessary to cover DSS's administrative costs. PPACA does not alter the current requirement that South Dakota must cover 50% of all Medicaid Program administrative expenses. It is estimated that South Dakota will expend an additional $37.1 million to cover PPACA related administrative expenses for 2014 through 2019.

16. Though theoretically possible, South Dakota cannot cease participation in the Medicaid Program. Currently, South Dakota is required to continue participation as a condition it agreed to when it accepted ARRA funds for Medicaid related costs. This agreement allowed South Dakota to free up state funds needed for other state expenditures due to revenue short falls arising during the latest recession. Even without the receipt of ARRA funds, it is not economically feasible for South Dakota to terminate its Medicaid Program and separately provide comparable benefits to South Dakota citizens. South Dakota's Medicaid budget (state and federal funds) for state fiscal year 2011 is $877,749,102.00. To provide pre PPACA

Medicaid benefits, South Dakota would be required to expend 75.58% of its total state general fund budget. There simply would not be enough money remaining to fund other vital state programs such as education. Further, to terminate the Medicaid Program and not provide comparable benefit coverage, would be very detrimental to the 101,000 persons who monthly receive healthcare paid by the South Dakota Medicaid Program. For example, Medicaid pays for 60% of the individuals living in South Dakota nursing homes.

17. Termination of South Dakota's participation in Medicaid would also have a severe impact on the state's healthcare providers. For example, approximately 60% of nursing home revenue is through Medicaid. Medicaid constitutes between 10 and 12% of general hospital revenues in any given year. This amount increases to approximately 25.2% for rural health care clinics and federally qualified clinics.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 21st day of September, 2010.

_____

Deborah K. Bowman
Secretary, Department of Social Services
Kneip Building
700 Governors Drive
Pierre, SD 57501

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-5

DECLARATION OF SANDRA J. ZINTER

Pursuant to 28 U.S.C. § 1746, I, Sandra J. Zinter, declare the following:

1. I am the Commissioner of the South Dakota Bureau of Personnel and have acted in that capacity since my initial appointment on June 6, 1995. As commissioner, I am charged with overseeing the activities of the South Dakota Bureau of Personnel (BOP).

2. This Declaration is based upon personal knowledge, information received from my staff based upon their personal knowledge, and records maintained by BOP.

3. BOP is the state agency authorized under South Dakota Codified laws chapter 3-12A to establish and administer health, life and flexible-spending benefit insurance plans for eligible state employees, former employees who wish to continue coverage under COBRA, retired employees and their dependents (State Plan). The State Plan is self-insured. The State Plan is funded by appropriations from the South Dakota Legislature and various member payments. For state fiscal year 2011, the Legislature has appropriated approximately $78,000,000 for the State Plan.

[* * *]

cost for coverage under the State Plan could be much higher if dependents are included and COBRA is applicable.

10. ACA § 6301, effective 2012, requires South Dakota to pay the federal government a $1 comparative effectiveness excise tax for each member of the State Plan. This excise tax is $2 per member for 2013 and the tax is payable annually through 2018 with inflationary increases. The estimated cost of the seven year excise tax without the inflation increases is $460,000.

11. It is estimated that the lifetime annual policy limit provisions (ACA § 1001, PHSA § 2711) will cost South Dakota an additional $1,000,000 for state fiscal year 2012 which will escalate thereafter due to increased healthcare costs and an aging state work force. It is estimated that the required preventative care requirements

(ACA § PHSA 2713) will cost South Dakota an additional $2,000,000 annually. It is estimated that the immediate impact of the preexisting condition requirements for individuals up through age 18 (ACA § 1201, PHSA § 2704); dependent coverage requirements (ACA § 1001, PHSA § 2714); and reporting requirements (ACA § 1001, PHSA § 2718) will cost South Dakota an additional $150,000 annually.

12. Additionally, there will be other ACA compliance related cost increases to the State Plan which BOP is unable to estimate at this time. BOP is unable to provide cost estimates regarding ACA §§ 1511 and 1513 that create potential liability by penalizing South Dakota due to state employees choosing to enroll in a federal-subsidized plan from an exchange instead of the State Plan. Also, BOP is unable to determine whether the benefits provided under the State Plan will subject South Dakota to potential liability for providing "high cost" benefits that exceed a federally defined threshold (ACA § 9001).

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 29th day of September, 2010.

_____

Sandra J. Zinter, Commissioner
Bureau of Personnel
500 E. Capitol Building
Pierre, SD 57501

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-5

DECLARATION OF BILLY R. MILLWEE

Pursuant to 28 U.S.C. § 1746, I, Billy R. Millwee, declare the following:

My name is Billy Millwee. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Texas Health and Human Services Commission (HHSC) as the Associate Commissioner for Medicaid and the Children's Health Insurance Program (CHIP), also referred to as the State Medicaid/CHIP Director.

I have served as State Medicaid/CHIP Director since January 2010. I have 15 years experience working in the Medicaid program, including serving

as the deputy Medicaid/CHIP director, administering the Medicaid claims administration contract with the Texas Medicaid and Healthcare Partnership, and managing HHSC's Medicaid Eligibility and Health Information System.

As the State Medicaid/CHIP Director, I am responsible for administering the Texas Medicaid program, including serving as the primary point of contact with the federal government and implementing policy direction established by the Texas Legislature and state leadership. Based on my employment, I am familiar with the Patient Protection and Affordable Care Act (PPACA) and the effects of PPACA on the Texas Medicaid program.

I am making this affidavit in connection with State of Florida, et al. v. United States Department of Health and Human Services, et al., a lawsuit to which the State of Texas is a party.

A. The Texas Medicaid Program

Congress established the Medicaid program under Title XIX of the Social Security Act of 1965. Following authorization by the Texas Legislature, Texas began participating in the Medicaid program in September 1967.

The Texas Medicaid program consumes approximately 25% percent of the State's budget.[1] For FY 2009-2010, Texas will spend $22 billion/year

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[1] *See* General Appropriations Act, Chapter 1428, 80th Leg., R.S., 2007; General Appropriations Act, Chapter 1424, 81st Leg., R.S., 2009.

on Medicaid services to approximately 4.3 million individuals.[2]

HHSC has been the single state agency for the Texas Medicaid program since January 1993. As the single state agency, HHSC's Medicaid responsibilities include:

- Administering the Medicaid State Plan;
- Contracting with the various state departments to carry out certain operations of the Medicaid program;
- Operating the state's acute care, vendor drug, and Medicaid managed care programs;
- Determining Medicaid eligibility; and
- Approving Medicaid policies, rules, reimbursement rates, and oversight of operations of the state departments contracted to operate Medicaid programs, subject to direction from the Texas Legislature and state leadership.

In Texas, HHSC delegates some day-to-day operations of the Medicaid program to other state agencies, such as the Texas Department of Aging and Disability Services, the Texas Department of Assistive and Rehabilitative Services, and the Texas Department of State Health Services.[3] Each of these operating departments will be impacted by PPACA.

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[2] *Id.*

[3] *See* Attachment 1, *Figure 3.3: Medicaid Operating Departments, 2008*, Texas Medicaid in Perspective, 7th Edition, January 2009, p. 3-10.

B. Impact of PPACA

Restrictions on State Ability to Define Eligibility and Tailor Medicaid Programs

PPACA precludes a state from adopting eligibility standards, methodologies, or procedures for Medicaid or CHIP that are more restrictive than those in place on March 23, 2010, the date PPACA was signed into law.[4] This requirement is the "maintenance of effort" requirement.

The maintenance of effort requirement means that Texas cannot make any change to eligibility that would render a person ineligible for Medicaid or CHIP benefits when that same person would have been eligible for benefits on March 23, 2010. If Texas fails to comply with the maintenance of effort requirement, it risks losing federal matching funds for *all* Medicaid programs, including funds that support services to pregnant women, children, and the aged and disabled populations.

Through the maintenance of effort requirement, PPACA severely restricts the discretion of the Texas Legislature and state leadership to design programs and allocate the state's limited resources in the way that best serves all Texans. Further, by imposing an immediate freeze effective on the date of its passage, PPACA deprives the state of any opportunity to evaluate its current allocation of resources and to make adjustments in preparation for the long-term commitments required under the Act.

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[4] PPACA, § 2001(b).

Women's Health Program

The Women's Health Program (WHP) is a five-year Medicaid demonstration project authorized by the Texas Legislature in 2005 to expand access to preventive health and family planning services for women. The statute authorizing the project, section 32.0248 of the Texas Human Resources Code, expires September 1, 2011. CMS approved the state's request for a demonstration project and HHSC implemented the WHP beginning January 1, 2007. The WHP is scheduled to expire December 31, 2011.

Although HHSC believes that the statutory and CMS-approved expiration dates are not a "more restrictive" eligibility standard, methodology, or procedure than was in effect before March 23, 2010, CMS's interpretation of the maintenance of effort requirement indicates that CMS may require Texas to maintain coverage of all clients served through the WHP until the maintenance of effort requirement expires. Thus, Texas may be required to extend the WHP even if the Legislature decides not to renew or extend the statute beyond September 1, 2011, or wishes to change the scope of program benefits or conditions of eligibility.

HHSC has asked CMS for guidance as to whether Texas may rely on CMS's prior approval and allow the project to expire by its terms without violating the maintenance of effort requirement. Further, HHSC asked CMS for guidance as to whether, if CMS believes failure to renew the statute would violate the MOE provision, Texas will need to take specific action, either through an extension or

State Plan amendment, to continue the program.[5] CMS has not yet responded.

Home and Community-Based Services Waiver Programs

Medicaid Home and Community-Based Services (HCBS) waiver programs are optional programs created by a state, with permission from CMS, under §1915(c) of the Social Security Act. Through the use of waiver programs, a state can provide a broad array of home and community-based services to targeted populations as an alternative to institutionalization. States historically have had discretion to tailor the size of HCBS waiver programs and to allocate funding to accommodate changing service needs and limits on available resources.

Under PPACA, it is not clear that the state retains the discretion to control the services or size of its waiver programs. PPACA requires the state to maintain eligibility standards, methodologies, and procedures for a waiver program and gives the state the option of rolling the waiver services into the State Plan services; it is not clear whether these instructions are meant to preclude termination or reduction in the size of a waiver program.

CMS has not issued guidance on the application of PPACA's maintenance of effort requirement to the HCBS waiver programs. However, CMS did issue guidance on the application of a similar maintenance

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[5] *See* Attachment 2, Letter from Billy R. Millwee to Juliana Sharp, dated July 16, 2010, concerning the Women's Health Program.

of effort requirement in the American Recovery and Reinvestment Act (ARRA). In State Medicaid Director Letter #09-005, CMS provided a list of examples that CMS considers to be restrictions on "eligibility standards, methodologies, or procedures," that includes:

- Reducing occupied waiver capacity for section 1915(c) HCBS waivers.
- Reducing or eliminating section 1915(c) waiver slots that were funded by the legislature but unoccupied as of July 1, 2008.[6]

These restrictions could be interpreted to limit the Texas Legislature's discretion to allocate funding for waiver programs. Texas may not have the flexibility to implement small reductions in funds appropriated for some waiver programs based on budget constraints and performance goals that are intended to assure client service needs.

HHSC has asked CMS to reconsider its interpretation of ARRA's maintenance of effort requirement and to provide guidance on the application of PPACA's similar requirement to the HCBS waiver programs.[7]

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[6] State Medicaid Director Letter (SMDL) #09-005, available at http://www.cms.gov/SMDL/downloads/SMD081909.pdf (Letter) and http://www.cms.gov/SMDL/downloads/SMD081909Att2.pdf (Enclosure B), last visited September 2, 2010.

[7] *See* Attachment 3, Letter from Billy R. Millwee to Cindy Mann, dated September 1, 2010, concerning the HCBS Waiver Programs.

Treatment of Children and Adults in Optional Programs

PPACA establishes separate maintenance of effort requirements for the adult and children's Medicaid populations and, as a result, significantly alters the state's expectations for coverage of optional categorically needy populations. The maintenance of effort requirement for the adult Medicaid population will remain in place until the U.S. Department of Health and Human Services (HHS) determines that the state's health insurance exchange is fully operational.[8] The maintenance of effort requirement for CHIP and the children's Medicaid population up to age 19 will remain in effect through September 2019.[9]

Consistent with federal law, Texas has opted to cover, as optional categorically needy groups, individuals who are eligible under a special income level and who are in nursing facilities; ICF-MR facilities; acute care hospitals; and institutions for mental diseases for individuals over the age of 65. With one exception, these groups—unlike the PPACA's maintenance of effort requirements—are not age-specific.

HHSC created these groups according to policy direction from state leadership and with the understanding that, in accordance with federal statute and regulation, if the state provided Medicaid coverage to one eligible individual in a group, it would provide Medicaid coverage to all

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[8] PPACA, § 2001(b).

[9] *Id.*

eligible individuals. If, therefore, the state provides Medicaid coverage to children in an optional categorically needy group that is not age-specific, the state also must cover adults in the same group. So, while PPACA's maintenance of effort requirement for the adult Medicaid population purportedly ends when the health insurance exchange is operational, it is in effect extended through September 2019 with respect to adults in these non-age-specific, optional categorically needy groups. As a result, Texas is forced to provide Medicaid coverage to adult and child members of an optional categorically needy group through September 2019, although it may be more cost-effective for the state if the adult group members can be covered through the Exchange.

Primary Care Physician Rate Increases

PPACA increases Medicaid rates for primary care services furnished in 2013 and 2014 to not less than 100 percent of the Medicare rates for similar services.[10] HHSC projects that the required rate increase will cost Texas approximately $631 million/year.[11] Because of the difficulties inherent in reducing provider reimbursement rates, HHSC assumes in its projections that the rate increase would continue beyond the two-year period delineated in the law.

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[10] PPACA, § 1202.

[11] These projections were developed by HHSC Strategic Decision Support staff (HHSC SDS) based on claims information maintained by the TMHP's Medicaid Acute Care Claims Payment System.

Loss of Prescription Drug Rebate Revenue

PPACA modifies the minimum Medicaid federal unit rebate amount for most drugs.[12] These modifications were made retroactively effective to January 1, 2010, and have the effect of reducing the supplemental rebates available to the states.

CMS provided initial guidance to states regarding PPACA's pharmacy rebate provisions on April 22, 2010.[13] In this initial guidance letter, CMS indicated that it would retain the difference between the old and new rebate percentages across the board for all drugs, not just for those drugs for which there is an actual increase in the federal rebate amount due to the Act.

Texas Medicaid requested that CMS revise its position.[14] On July 28, HHSC received draft guidance that proposed two options for calculating the federal recapture of the federal rebates.[15] The new approach proposed by CMS would limit the rebate amount that is recaptured by CMS to the amount of increase attributable to PPACA.

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[12] PPACA, § 2501.

[13] *See* State Medicaid Director Letter #10-006, available at http://www.cms.gov/smdl/downloads/SMD10006.pdf, last visited September 2, 2010.

[14] *See* Attachment 4, Letter from Thomas Suehs to Kathleen Sebelius, dated June 1, 2010, concerning Medicaid drug rebate programs.

[15] *See* Attachment 5, *CMS Draft Guidance Document*, Methodology for Calculating the Estimated Quarterly Rebate Offset Amount.

HHSC currently estimates that Texas will lose approximately $70.4 million in rebate revenue from January 2010-August 2013.[16] During that same timeframe, the state will receive approximately $1.5 billion in rebate revenue.[17]

Intrastate Insurance Exchange

PPACA requires Texas to establish one or more Health Insurance Exchanges, or the federal government will do so.[18] An Exchange must be operated by a governmental entity or non-profit organization. If, by January 1, 2013, the federal government determines that Texas will not be ready to operate an Exchange by January 1, 2014, the federal government will designate an entity to operate an Exchange for the State. Texas is exploring whether to establish one or more Exchanges.

No single entity has been designated to design or operate an Exchange if Texas opts to do so. We anticipate receiving further direction the establishment and operation of the Exchange when the Texas Legislature meets from January - May 2011. In the meantime, HHSC and the Texas Department of Insurance (TDI) are coordinating preliminary Exchange planning activities.

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[16] These projections were developed by HHSC Forecasting staff based on information from the Texas Medicaid Vendor Drug claims extract file maintained by FirstHealth, HHSC's pharmacy claims administrator, and the rebate estimate analysis prepared by HHSC Forecasting.

[17] *Id.*

[18] PPACA, § 1311.

If Texas chooses to establish an Exchange, HHSC will incur costs associated with Exchange planning and operations. HHSC's eligibility and enrollment experience will be necessary to begin to plan and estimate costs for the eligibility and enrollment infrastructure required for the Exchange. In addition, regardless of which entity operates the Exchange in Texas, HHSC will be responsible for closely coordinating with the Exchange for streamlined eligibility and enrollment for the Exchange, Medicaid and CHIP. HHSC also will be involved in outreach to vulnerable populations who may be eligible for Medicaid, CHIP, or Exchange subsidies and cost sharing assistance.

For the purposes of estimating costs to develop and operate the Exchange, and pending federal guidance, HHSC has taken the lead in analyzing and estimating costs associated with: eligibility and enrollment; subsidy determination; premium payment; and eligibility-related customer service functions. HHSC expects significant planning and system development efforts from 2011-2013 in order to be ready to operate an Exchange by January 1, 2014.

Medicaid Eligibility Expansion

PPACA expands Medicaid eligibility to all individuals under 65 with incomes of up to 133% of the Federal Poverty Level (FPL).[19] Based on 2008 Census Bureau statistics, Texas has 6,500,000

[19] PPACA, § 2001(a).

uninsured residents. Of those, 2,145,000 Texas citizens have incomes below 133% of the FPL.[20]

In Texas, this expansion means that several new populations will be eligible for benefits, including: parents and caretakers with incomes from 14% to 133% of FPL; childless adults up to 133% of FPL; foster-care recipients through age 25; and emergency Medicaid in expansion populations. Texas anticipates caseload growth as a result of these newly eligible individuals as well as individuals who are currently eligible for services but not enrolled.

The expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level will increase Texas's costs, less so in the early years but more so after 2016. HHSC projects PPACA will increase the state's costs by $1.0 billion / year between 2014 and 2016. This will increase to an estimated $2.1 billion/year between 2017 and 2019. Between 2020 and 2023, HHSC projects the state's costs will run to approximately $4.4 billion/year.[21]

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional

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[20] Information provided by HHSC SDS, based on data from the U.S. Census Bureau, March 2009 Current Population Survey – Texas Sample – 2008 figures.

[21] These projections were developed by HHSC SDS based on data from the U.S. Census Bureau, March 2009 Current Population Survey – Texas Sample – 2008 figures and TMHP, Medicaid Acute Care Claims Payment System.

information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 4 2010, in Austin, Texas.

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BILLY R. MILLWEE
Texas State Medicaid Director

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

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UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-6

STATE OF TEXAS
COUNTY OF TRAVIS

DECLARATION OF ROBERT KUKLA

Pursuant to 28 U.S.C. § 1746, I, ROBERT KUKLA, declare the following:

"My name is ROBERT KUKLA. I am of sound mind. I have personal knowledge of each of the facts stated herein, and I am competent and authorized to make this affidavit.

I hold the position of Director of Benefit Contracts for the Employees Retirement System of Texas (ERS). Additionally, I have a number of years of professional group insurance underwriting and other insurance industry experience.

My official duties at ERS include managing the Benefit Contracts division of ERS. The division manages the vendors and providers who serve as administering firms within the Texas Employees Group Benefit Program ("GBP"), including, but not limited to, third party administrators and HMOs for GBP health insurance. I oversee all benefit contract areas from procurement to award to contract monitoring, contract compliance and contract enforcement. Benefit Contracts is also responsible for the administration of the Social Security program for all public entities in the State of Texas. In addition, I am familiar with, and it is my official duty to manage the insurance coverage contributions and benefits provided under the GBP and administered by ERS. In the course of my duties, I am responsible for supplying information responsive to legislative inquiries regarding the GBP, among other duties.

The furnishing of the following information is within my official duties and those duties include making an accurate report, which has been done here. All of the statements contained herein are true and correct, and prepared by or received by ERS in the ordinary course of its business.

GBP Eligibility, "full time employees" and waiting periods:

Eligible GBP participants include state officers and employees who perform services for the State of Texas and their dependents, employees and retirees of certain institutions of higher education and their dependents, as specified by Texas Insurance Code Ch. 1551.

Additionally, the Health Select of Texas[SM] Plan within the GBP is a self-funded health plan. There are also two fully insured HMOs within the GBP for which ERS serves as the plan sponsor. Since at least 1993, the State has paid 100% of the cost of member coverage and 50% of the cost of dependent coverage. Accordingly, any increase or decrease in GBP costs attributable to a member would be borne by the State at 100%, and any increase or decrease in GBP costs attributable to dependent coverage would be split 50%/50% by the State (including higher education) and member, under the current plan.

ERS' statutory waiting period, in Tex. Ins. Code § 1551.104 provides that all "full time" employees are covered automatically by the GBP, subject to a waiting period that is never shorter than 90 days, but may be longer than 90 days, i.e. the first day of the month following the completion of 90 days of service. *Id.* at § 1551.055 (*see also* 24 Texas Administrative Code § 81.5). Under the current General Appropriations Act, the state pays 100% of the insurance contributions for each such employee. *Id.* at § 1551.319(a). All part-time employees are offered an opportunity to enroll as well. Any person working fewer than 40 hours per week is considered to be a "part-time" employee, *Id.* at § 1551.003(11), and must pay one-half of the contribution for coverage, *Id.* at § 1551.319(b). If the part-time employee agrees to pay his or her share of the contributions, then he/she is permitted to enroll in the program.

Impacts of federal health care reform not contained in LAR:

ERS is required to submit estimates and reports relating to appropriations requested by the Texas Legislative Budget Board (LBB) or under the board's direction. In May, 2010, the LBB instructed ERS to prepare and submit its Legislative Appropriations Request for Texas State Fiscal Years 2012-2013 (September 1, 2011 to August 31, 2013) (hereinafter the "LAR"). The LBB instructions required ERS to estimate the budgetary impact to the GBP of federal health care reform: Patient Protection and Affordable Care Act of 2010 ("PPACA;" Public Law 111-148), and the Health Care and Education Reconciliation Act of 2010 ("HCERA;" Public Law 111-152)(collectively referred to as "federal health care reform" and/or PP ACA).

Various expected cost impacts of federal health care reform were supplied to the LBB by ERS as required. *See* Declaration of Michael Wheeler, ERS Chief Financial Officer; *see also,* Declaration of Philip S. Dial, FSA, Rudd and Wisdom, Inc., ERS consulting actuary.

However, based on the limited, specific instructions the LBB requested for the LAR, such as the specific state fiscal years to be included, and with LBB recognition of uncertainties in federal health care reform, the following federal health care reform provisions were not addressed in the LAR. If the following provisions are applicable to ERS and no exceptions apply, ERS expects at least the following requirements to have a negative cost impact to the GBP, though ERS has not estimated

exact figures and/or has insufficient information to do so at this time:

Reporting:

If ERS is a group health plan providing minimum essential coverage and the federal health care reform "reporting" provisions [PPACA Sec. 1501 *et seq*.] require ERS or its third-party administrator(s) to issue statements to individuals about coverage, those requirements would require ERS to incur costs or pay its contractors to prepare such reports and statements. Those costs have not been calculated or estimated for the GBP and/or require input or direction from Texas legislative leadership.

Broader Automatic enrollment:

As described above, if ERS is subject to the automatic enrollment of "full time" employees as defined by federal health care reform, ERS expects the GBP to incur costs when additional participants are automatically enrolled who might otherwise not elect to be enrolled, and/or possibly be subject to the application of potential) penalties if it fails to automatically enroll these employees as defined by federal health care reform. Those costs have not been calculated or estimated for the GBP and/or require input or direction from Texas legislative leadership.

Insurance Exchange:

If ERS is subject to the various federal health care reform requirements for insurance

exchange(s) [PPACA Sec. 1301 *et seq,* 1402], such as but not limited to establishing the health insurance exchange, participating in the exchange, being assessed penalties for (potentially) not offering qualified coverage, providing notice to individuals, etc., ERS expects the GBP to incur costs and/or possibly be applied fines. Too little is known about the exchange, and those costs have not been calculated or estimated for the GBP and/or require input or direction from Texas legislative leadership.

Rescissions:

If ERS is subject to the federal health care reform prohibitions of group health plan coverage rescissions once an enrollee is covered, except in cases of fraud or material intentional misrepresentation [PPACA Sec. 2712], ERS expects the GBP to incur costs because the GBP currently provides for rescission in cases of negligence and mistake for coverage that would otherwise be rescinded but for federal health care reform. Those costs have not been calculated or estimated for the GBP and/or require input or direction from Texas legislative leadership. Independently, the GBP cannot reliably estimate the number of future expected cases of negligence or mistaken coverage.

Evidence of Insurability:

If ERS is subject to the federal health care reform evidence of insurability prohibitions [PP ACA Sec. § 1201 amending PHSA § 2705] and those prohibitions apply to ERS late enrollees as defined by the GBP, which is unclear to ERS,

ERS would expect the GBP to incur costs because the GBP currently screens late enrollees for evidence of insurability. Those costs have not been calculated or estimated for the GBP and/or require input or direction from Texas legislative leadership. Independently, the GBP cannot reliably estimate the number of late enrollees who would have otherwise been excluded for lack of evidence of insurability.

Grandfathered Status:

ERS has not determined grandfathered status and/or made elections to modify or revoke any plan changes that would result in loss of grandfathered status as permitted by federal health care reform [PP ACA Sec. § 1251(e)] on or before August 31, 2011. ERS expects that any GBP loss of grandfathered status would result in additional cost to comply with federal health care reform that would have otherwise been grandfathered. The loss of grand fathered status has not been confirmed by ERS, nor have all costs of any such loss been calculated or estimated for the GBP and/or require input or direction from Texas legislative leadership.

I reserve the right to amend my testimony, as permitted by the Court, if additional federal regulations or guidance is issued, and/or costs become known to ERS and/or relevant input or direction from Texas legislative leadership is received to permit various calculations and estimates.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 29th day of September, 2010.

Robert Kukla, Director of Benefit Contracts
Employees Retirement System of Texas

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

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Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-6

DECLARATION OF NEAL T. GOOCH

1. Pursuant to 28 U.S.C. § 1746, I, Neal T. Gooch, being first duly sworn upon oath, declare as follows:

2. I have personal knowledge of the matters set forth in this Declaration.

3. I am and since May 19, 2010 have been the Utah Insurance Commissioner. Under the Utah Insurance Code (Title 31A, Utah Code Ann.), the Commissioner is the chief officer of the Utah Insurance Department ("Department").

4. From about September 1, 1997 to January 15, 2010, I served as Utah's Deputy Insurance Commissioner.

5. From January 15, 2010 to May 19, 2010 I served as Utah's Acting Insurance Commissioner.

6. Since the enactment of the Patient Protection and Affordable Care Act ("PPACA") on March 23, 2010, the focus of the Utah Insurance Department has been to understand PPACA and its impact on the work of the Department and the Utah insurance market.

7. The director of the Utah Insurance Department's Health Insurance Division has had to allocate a substantial portion, if not the principal amount of her work schedule toward identifying which provisions of PPACA relate to the insurance market in Utah and developing a strategy to prevent affected Utah insurance statutes from being preempted by PPACA so that the regulation of insurance will remain under my jurisdiction.

8. The most immediate impact of PPACA arises from the provisions in PPACA related to changes in insurance coverage in the insurance market. These changes required the department to reallocate some of its resources in the Health Insurance Division, the Producer Licensing Division, the Market Conduct Division and the Property and Casualty Life Division to meet the demands of PPACA.

9. Because of the enactment of PPACA, the individuals in the Utah Insurance Department's Health Insurance Division have had to triage their work and work only on PPACA implementation and only address non-PPACA matters that are critical to the welfare of the

current market. This has limited their ability to perform their duties as set forth in the Utah Insurance Code.

10. The two (2) full-time employees at the Utah Insurance Department's Office of Consumer Health Assistance, who are tasked with educating the public on insurance matters and assisting them with non-PPACA complaints and inquiries relating to insurance companies and coverage, have also had to limit their work on their statutorily mandated job assignments because they have been spending substantial time on PPACA.

11. The fiscal impact on the Utah Insurance Department's General Fund appropriation arising from reallocating resources within the Department to perform PPACA related duties is $628,000 per year.

Reinsurance Program - PPACA § 1341

12. The situation is similar for the reinsurance mandates of PPACA. In 2009, it is estimated that the State of Utah had 302,400 uninsured individuals. It is estimated that 10% of those individuals would be classified as being uninsurable and will therefore be considered uninsurable or high risk individuals under PPACA. PPACA will require these 302,400 individuals to be to be insured in the market place and that the risk of the 30,000 high risk individuals in the State of Utah risk is to be managed with a risk adjustment mechanism specified in PPACA. This risk adjustment function will require an agency to administer

the risk allocation among insurance companies that is required by PPACA. It is estimated that such an agency will require a significant number of full-time employees and other costs to staff the operations of such an agency.

13. The cost to the Department's General Fund appropriation of establishing and operating such an agency to administer and implement the risk adjustment system associated with the federally mandated health exchange system and is estimated to be $2,008,900 per year.

Premium Review Process

14. Another impact of PPACA is that it requires the Department to change the form and rate regulation and review scheme and process in regard to health insurance products that will be required to be offered both in and out of the exchange mandated by PPACA. Current law is a file and use statutory scheme. Products offered in the mandated federal exchanges will have to be filed, reviewed and certified before they can be used in the exchange. This will create a dual system and require the Department's rate and form analysts to be trained to apply the requirements imposed upon the policy form and rate review process by PPACA. For the rate review after the federal grants terminate, the state will have to fund the costs imposed by the new review process. The additional burden for certification of health insurance policy forms will be bourn fully by the State. We estimate those costs to the department's General Fund appropriation be $1,501,100 per year.

Health Insurance Exchange

15. Currently, the State of Utah has a Health Insurance Exchange organized in the Governor's Office of Economic Development. This exchange, organized as an independent effort by the State to mitigate the costs of the health insurance premiums to its residents, does not include many of the functions and services mandated under PPACA. As a result, I anticipate that the cost to the State of Utah in implementing the requirements of PPACA for its Health Exchange will be significant. It is my understanding that to make the current health exchange compliant with PPACA, the exchange will need a call center, administrative functions, program functions and technology and other functions that are currently not part of the regulatory oversight scheme of the industry or government and will require a full time staff to provide the services and regulation required under PPACA.

DATED this 2nd day of September, 2010.

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Neal T. Gooch
Utah Insurance Commissioner

STATE OF UTAH
COUNTY OF SALT LAKE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

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UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-6

DECLARATION OF DAVID N. SUNDWALL, M.D.

STATE OF UTAH
COUNTY OF SALT LAKE

I, David N. Sundwall, M.D., being first duly sworn, declare as follows:

1. I am over the age of twenty-one and am familiar with the facts set forth herein.

2. I am a physician licensed to practice in the State of Utah.

3. I am the Executive Director of the Utah Department of Health, the single state agency

operating the Medicaid program in the State of Utah.

4. I am responsible for the preparation of the budget of the Medicaid program and am personally familiar with the records that support the assertions in this affidavit.

5. Utah joined the federal Medicaid program shortly after it was created by Congress in the 1960s. In 1981 the Utah Legislature enacted the "Medical Assistance Act" in Title 26, Chapter 18 of the Utah Code.

6. The Utah Legislature requires the Medicaid program to be operated in the most economical and cost-effective manner possible. Utah Code Ann. § 26-18-2.3 (l)(c) (Supp. 2010).

7. Utah's continued participation in the Medicaid program is based on the expectation that the terms of its participation would not be altered significantly by the federal government to increase the control of the federal government and to reduce Utah's discretionary authority.

8. The Patient Protection and Affordable Care Act ("the Act") expands eligibility for enrollment beyond Utah's ability to fund its participation. Under existing eligibility criteria, individuals applying for Medicaid must be under an income threshold, be under an asset threshold, and fit into a category of need (i.e., disabled, pregnant, etc.).

9. The Act increases the income threshold, eliminates the asset threshold, and eliminates categories of need. As a result, all Utahns under

133% of the federal poverty level (about $30,000 for a family of four) will qualify for Medicaid beginning January 1, 2014.

10. Utah projects this will result in at least 110,000 new individuals enrolling in Medicaid at that time. The current average monthly enrollment is about 210,000 individuals.

11. The costs for these "newly eligible" enrollees will be covered by 100% federal funds for the first three years of the expansion. But that federal participation erodes to 90% in 2020.

12. The Act's new mandate for individuals to maintain health insurance coverage will create an increased incentive for families currently eligible but not enrolled in Medicaid to enroll. Utah will have to cover the costs of this increased enrollment at the traditional match rate: about a 70/30 federal-state split.

13. Medicaid and Children's Health Program outlays for Utah consume 19% of Utah's budget.

14. For FY 2009-2010, Utah spent $230 million in state funds on Medicaid. The projected increases in state funds needed for Medicaid under the Act are $37 million in 2014, eventually growing to $157 million in 2021.

15. The Act therefore forces Utah to increase state funding for these programs from current levels by 16% in 2014, increasing year by year to 68% in 2021.

16. It would not now be feasible for Utah to cease its participation in Medicaid and make alternative

arrangements for a traditional Medicaid-like program prior to the Act taking effect.

17. The added costs to Utah under the Act would not be offset by increased federal contributions under the Act.

18. The Act also will also require Utah to provide medical services, as distinguished from providing payment for medical services. The future costs to the state of this mandate are potentially massive, but have not yet been quantified.

DATED this 2nd day of September, 2010.

_____

David N. Sundwall, M.D.
Executive Director
Utah Department of Health

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-9

DECLARATION OF JERRY DUBBERLY

Pursuant to 28 U.S.C. § 1746, I Jerry Dubberly, declare the following:

I am over the age of twenty-one and am familiar with the facts set forth herein.

I am a pharmacist licensed to practice in the State of Georgia.

I am the Medicaid Director of the Georgia Department of Community Health, the single state agency operating the Medicaid program in the State of Georgia.

I am responsible for the preparation of the budget of the Medicaid program and am personally

familiar with the records that support the assertions of this affidavit.

Georgia joined the federal Medicaid program shortly after it was created by Congress in the 1960s. In 1981, the Georgia General Assembly created the Department of Community Health in Title 31, Chapter 2 of the Georgia Code.

The Patient and Protection Affordable Care Act (the "PPACA") expands eligibility for enrolment beyond Georgia's current ability to fund its participation. Under existing eligibility criteria, individuals applying for Medicaid must be under an income threshold, be under an asset threshold, and fit into a category of need (i.e., disabled, pregnant, etc.).

The Act increases the income threshold, eliminates the asset threshold, and eliminates categories of need. As a result, all Georgians under 133% of federal poverty level (about $30,000 for a family of four) will qualify for Medicaid beginning January 1, 2014.

Georgia projects this will result in a least 560, 769 new individuals enrolling in Medicaid at that time. The current average monthly enrollment is about 1,477,838.

The costs for these newly eligible enrollees will be covered by 100% federal funds for the first three years of expansion. But that federal participation erodes to 90% in 2020.

The Act's new mandate for individuals to maintain health insurance coverage will create an increased incentive for families currently eligible but

not enrolled in Medicaid to enroll. Georgia will have to cover the costs of this increased enrollment at the traditional match rate: approximately 65/35 federal-state split.

Medicaid and Peachcare for Kids outlays for Georgia consume 11.8% of Georgia's current budget. The portion of the state budget dedicated to health care is projected to increase to approximately 14.3% by 2014.

It is estimated that there will be a 31.7% increase in Medicaid and PeachCare for Kids membership due to the PPACA beginning in 2014.

For FY 2009-2010, Georgia spent $1.733 billion in state funds on Medicaid benefits. The projected increases in state funds needed for Medicaid under the Act are $71.2 million in 2014, eventually growing to $410.8 million in 2019.

It would not now be feasible for Georgia to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid-like program prior to the PPACA taking effect.

The added costs to Georgia under the Act would not be offset by increased federal contributions under the PPACA.

The PPACA also will required Georgia to provide medical services, as distinguished from providing payment of medical services. The future costs to Georgia of this mandate are potentially massive, but have not yet been quantified.

DATED this 4th day of November, 2010.

_____

Jerry Dubberly
Medicaid Director
Georgia Department of Community Health

State of Georgia
County of Fulton

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/23/10
DOCUMENT NO.: 135-1

FURTHER DECLARATION OF VIVIANNE M. CHAUMONT

Pursuant to 28 U.S.C. § 1746, I, Vivianne M. Chaumont, being first duly sworn, hereby depose and state as follows:

1. My name is Vivianne M. Chaumont. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration.

2. I am the Director of the Division of Medicaid and Long-Term Care for the Nebraska Department of Health and Human Services (Nebraska DHHS). My responsibilities include the administration of the Medicaid program

which is subject to requirements of state and federal regulatory and statutory authority. Neb. Rev. Stat. § 68-904 to 906; Title XIX, 42 USC 1396a, et seq.

3. I am making this further declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Nebraska is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

4. I earlier provided an affidavit in this matter describing the impact the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA) would have on the Nebraska Medicaid program. That impact was analyzed by Milliman, Inc., an actuarial firm specifically retained by Nebraska DHHS for that purpose.

5. Since providing the aforementioned affidavit, Milliman has provided an updated written analysis of the impact of that federal law as it pertains to DHHS and the State's Medicaid program. A true and correct copy of the updated version of the report, with revised analysis, is attached and marked as Exhibit A.

6. The updated written analysis provided by Milliman was necessitated by a September 28, 2010 letter from the Centers for Medicare & Medicaid Services to state Medicaid directors, which revised previous instructions concerning the federal offset of Medicaid prescription drug rebates.

7. Based upon Milliman's updated written analysis and Nebraska DHHS records and projections prepared and maintained in the regular course of state business, I estimate that the PPACA will cost Nebraska between $458.2 million and $691.5 million for the period of Fiscal Year 2011 through Fiscal Year 2020. See Exhibit A.

8. I have reviewed Defendants' claim that the PPACA will save the State of Nebraska $36 million per year, which is based on a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report).

9. The State of Nebraska does not stand to save $36 million due to the savings elements described in the CEA report.

10. Defendants erroneously attribute savings by local governmental units to the State of Nebraska. CEA Report at 67-68. On the contrary, any savings realized by local governments from persons who newly enroll in Medicaid would actually increase costs for the State of Nebraska.

11. The CEA Report upon which Defendants rely also erroneously assumes the elimination of uncompensated care in Nebraska in the amount of $8.6 million ("Hidden Tax" estimate), CEA Report at 68, which is contrary to any known projections familiar to Nebraska DHHS. The CEA Report also bases this estimate on costs borne by both state *and local* governments. As a result, it is not accurate to attribute the full $8.6

million savings estimate to the State of Nebraska alone.

12. The CEA Report's "Hidden Tax" estimate is also likely overstated for another reason. Hospitals which report higher than average (disproportionate share (DSH)) uncompensated costs are eligible to receive payments to help defray those costs, if they otherwise qualify. As a result, part of this uncompensated care for the uninsured is currently being paid through the DSH program, which includes state and federal funding. Not all of the cost is absorbed into the higher premiums referenced in the CEA Report's "Hidden Tax" section. The DSH program will be phased out over time as uncompensated costs go down. However, there is no assurance that the higher employee health insurance premiums will be going down. Likewise, the CEA Report says that there "may" be increased enrollment that will "potentially" allow cost savings to the states.

13. The CEA Report upon which Defendants rely forecasts that additional savings "may come" from the Children's Health Insurance Program. CEA Report at 68. However, under the PPACA, no changes to eligibility regarding CHIP can be made until 2019. The current eligibility level for CHIP in Nebraska is 200%, which is higher than the 133% provided by the PPACA. There is no mechanism in place for the State to manage or reduce this cost.

14. The $36 million figure relied on by the Defendants from the CEA Report also is based

upon the federal government's provision of a 100% FMAP (CEA Report at 6, 70). As passed, however, the ACA does not provide for an indefinite 100% FMAP, but a federal contribution that decreases to 90% by 2019.

15. The CEA Report also states that the State of Nebraska and local governments spend at least $36 million on care for the uninsured, and estimate that the annual cost of Medicaid expansion to Nebraska's low income uninsured individuals would be $178 million, with Nebraska's share being approximately $18 million. However, the CEA Report bases its $178 million estimate on the number of low income uninsured individuals expanding equal to 55,345.

16. Based upon the updated analysis of Milliman, the number of low income uninsured individuals is likely to expand by far more than 55,345, as the CEA Report assumes. Instead, Milliman's analysis takes into account individuals who have the potential to enroll and estimates that enrollment will be at least 107,903 individuals, and possibly as high as 145,297 individuals (see Exhibit A), thus raising the cost to Nebraska.

17. Finally, the CEA Report bases its conclusions on income levels of 133% of the federal poverty line, not 133% with a 5% disregard, as included in the PPACA. As a result, the CEA Report does not reflect the current eligibility levels contemplated by the PPACA.

I declare under penalty of perjury that the foregoing is true and correct. The information and

projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

_____

Vivianne M. Chaumont
Director, Division of Medicaid and Long-Term Care
Department of Health and Human Services
Date: 11/22/10

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/23/10
DOCUMENT NO.: 135-1

DECLARATION OF ROBERT D. CHURCH, JR.

Pursuant to 28 U.S.C. § 1746, I, Robert D. Church, Jr, declare the following:

1. My name is Robert D. Church, Jr. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Alabama Medicaid Agency as the Commissioner of the Agency and as the Chief Financial Officer.

2. I have served as Chief Financial Officer since approximately November, 2009 and as Commissioner since November, 2010.

3. As Commissioner, I am the highest ranking official in the Alabama Medicaid Agency and am responsible for all activities of the Agency including the operation of the Medicaid program.

4. I am making this declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.,* a lawsuit to which the State of Alabama is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. Presently, Alabama Medicaid Agency has projected that the initial administrative cost to the state will total over $76,000,000 by the conclusion of state Fiscal Year 2015 as a result of the passage of PPACA. This amount increases going forward, and by 2018 the projected administrative costs to Alabama are estimated to be in excess of $35,000,000 annually from the state's general fund. There are, currently, no projected savings as a result of PPACA.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 19, 2010, in Montgomery, Alabama.

_____

Robert D. Church, Jr.
Commissioner
Alabama Medicaid Agency

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/23/10
DOCUMENT NO.: 135-1

DECLARATION OF ROBERT M. DAMLER

Pursuant to 28 U.S.C. § 1746, I, Robert M. Damler, duly affirm under penalties for perjury that I am over 18 years of age and am competent to testify in a court of law:

1. I am making this further declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Indiana is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

2. I am a Principal and Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

3. Indiana Code § 12-8-1-7 gives the secretary of the Indiana Family and Social Services Agency (FSSA) the power to employ experts and consultants to carry out the duties of the secretary and the offices. Under this power, the Secretary of FSSA hired Milliman, Inc. to provide consulting services related to the financial review of the Patient Protection and Affordable Care Act (H.R. 3590) as it relates to the provisions impacting the State's Medicaid program and budget.

4. I provided a declaration earlier in this matter certifying the authenticity of a report I provided to FSSA concerning PPACA's impact on the Medicaid program. That report is attached as Exhibit A to the declaration of Pat Casanova, the head of the Indiana Office of Medicaid Policy and Planning, which declaration was supplied as Exhibit 10 in support of the Plaintiffs' Motion for Summary Judgment. I am the principal author of that report.

5. In my report dated October 18, 2010 to FSSA, I projected that PPACA is likely to increase the Indiana expenditures on the Medicaid program to be between $2.6 billion and $3.1 billion through state fiscal year 2020. The FSSA report did not reflect savings to other areas of the Indiana budget.

6. I have reviewed Part II.C.1 of the memorandum filed on November 4, 2010, by the United States Department of Health and Human Services in support of its motion for summary judgment in this matter and Exhibit 33 thereto.

7. On pp. 39-41 of DHHS's summary judgment memorandum, DHHS claims that the PP ACA will save the State of Indiana millions of dollars per year. This claim is based on Exhibit 33 to DHHS's motion for summary judgment, a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009, and titled *The Impact of Health Insurance Reform on State and Local Governments* (CEA Report).

8. There are several assumptions used in the DHHS's calculations that are not consistent with the actual experiences of the State of Indiana. Under PP ACA, the State of Indiana would not be expected to save $338 million per year compared with current State indigent care programs (as described in the CEA report), but instead may incur an additional $50 million per year or more compared with current outlays for indigent care programs.

9. Page 34 of the CEA Report at Exhibit 33 presents an estimated annual increased Medicaid cost for Indiana of $62 million based on a Federal Medical Assistance Percentage (FMAP) of 90%. This calculation is based on adding to the State's Medicaid rolls 189,000 currently uninsured adults and parents at a cost of $2,974 per person per year, and 31,600

currently uninsured children at a cost of $1 ,898 per child per year. This equates to a total combined State and Federal outlay of $563 million for adults and parents and $60 million for children each year. My analysis shows that the CEA's estimated cost for parents and adults is too low at $2,974 per year. My estimate, based on Indiana-specific data of the actual age and gender of the uninsured population, with adjusted morbidity, would be approximately $3,600 per year, which is 21% greater than the CEA's $2,974 value. As a further comparison, the Kaiser Commission on Medicaid and the Uninsured report titled, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL" utilized an average cost for Indiana for the period of2014 to 2019 estimated to be $4,300 to $5,000. These values are estimates since full details were not published in the report.

10. Furthermore, the CEA's estimated annual increased Medicaid cost for Indiana in Exhibit 33 did not account for any parents or adults that are currently *insured* but who are likely to switch to the Medicaid program once that becomes available. My previously published estimate anticipates an additional 107,000 currently insured adults and parents will enroll in the Indiana Medicaid program, which is more than a 50% increase to the CEA's estimate of parents and adults likely to join the Indiana Medicaid program. In addition to my previously published estimates, the Kaiser Commission report previously referenced 216,000 to 338,000

uninsured adults and parents will be enrolled in Medicaid by 2019. In addition to the previously uninsured enrollment, the Kaiser Commission report anticipates total adult and parent Medicaid enrollment to expand by 298,000 to 427,000 including both the uninsured and insured populations.

11. The CEA's estimates were based on earlier versions of health care reform legislation that would have expanded Medicaid eligibility to 133% of the Federal Poverty Level (FPL), which is not consistent with the final PPACA legislation. While PPACA specifies an income threshold of 133 percent of FPL for the Medicaid expansion, it also requires states to apply an "income disregard" of 5% of FPL in meeting the income test. Therefore, the effective income threshold is actually 138% of FPL. *See* Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Centers for Medicare and Medicaid Services memorandum, April 22, 2010, at https://www.cms.gov/ActuarialStudies/Downloads/PP ACA 201 0-04-22.pdf (November 4, 201 0).

12. Adjusting the CEA estimate for the higher cost per recipient noted in paragraph 9 above (a 21% increase), the likelihood that currently insured adults and parents will switch to Medicaid under the new PPACA standards noted in paragraph 10 (a 50% increase), and the expanded Medicaid population at the higher FPL noted in paragraph 11 (a 5% increase), the Adult/Parent Population would cost an estimated $1,072 million (State and Federal

contribution combined) or $107 million State contribution at 90% FMAP. The $107 million State contribution would compare to the $56.3 million illustrated by the CEA.

13. The CEA calculations need further modifications. First, the illustration applied the 90% FMAP to the children population, which would not be appropriate. Rather, this population will receive the standard FMAP, which is approximately 66% for Indiana in FFY 2011. This 34% State contribution for children means that the State portion of the Medicaid increase will be $20 million, not $6 million as the CEA estimates on page 37, Table 2 of Exhibit 33. With this correction, the total estimate of the State's increased Medicaid exposure would be $127 million, as compared to the $62 million the CEA has estimated in Exhibit 33.

14. Section 1115 of the Social Security Act gives the Secretary of HHS authority to waive provisions of major health and welfare programs authorized under the Act, thus allowing states to use federal Medicaid and CHIP funds in ways that are not otherwise allowed under federal rules. Indiana received such a waiver for the Healthy Indiana Plan. Because of the waiver, in addition to adjusting the FMAP on the children population, the State of Indiana may incur lower FMAP on a portion of the expansion population. Indiana may lose the enhanced FMAP of 90% on the first 34,000 lives, which corresponds to the number of childless adults that are allowed under Indiana's Section 1115 waiver for the

Healthy Indiana Plan. Although a final decision has not been provided by CMS, the loss in the enhanced FMAP would have a significant financial impact on the Medicaid Assistance budget. The 24% reduction in FMAP yields an additional $75 million cost for Indiana per year of Federal funds. This would be added to the $127 million value noted in paragraph 13.

15. The CEA's illustrations for Indiana m Exhibit 33 also does not include an estimate for administrative costs for enrollment, claims processing, and other administrative functions of serving an additional 300,000 lives. The administrative costs are generally matched at 50% Federal share/50% State share. We estimate that state share of these administrative costs would be $28 million per year.

16. After accounting for the modifications listed in paragraphs 12-15 above, Indiana's share of increased Medicaid costs under PPACA may be estimated at nearly $230 million per year, as compared to CEA illustrated amount of $62 million per year.

17. Another aspect that is unique to Indiana and other state Medicaid agencies relates to the disabled population eligibility requirements. The State of Indiana operates as a Section 209(b) state, which allows the State of Indiana to have different disability eligibility criteria. Since Indiana is a Section 209(b) state, it also provides eligibility under a spend-down provision requiring recipients to spend down their excess

monthly income toward medical expenses before they are eligible for Medicaid. Due to this eligibility determination rule, there are approximately 22,000 individuals that are SST disabled that do not qualify for the Medicaid disability eligibility in Indiana. Although CMS has not yet provided a final determination, Indiana may not receive the enhanced FMAP for these additional individuals under the new eligibility provisions of ACA. To the extent that the standard FMAP applies to the disabled population, the additional cost to the State of Indiana would be $90 million per year. It does not appear that the CEA estimate included an adjustment for this population. By combining the annual cost savings noted in this paragraph of $90 million with the total of $230 million in paragraph 16, the cost could be re-stated as $320 million.

18. Exhibit 33 also over-estimates cost savings that Indiana is likely to realize as a result of the Medicaid Expansion. For example, the CEA has illustrated a value of $154 mill1on for the cost of the Healthy Indiana Plan. These funds may be diverted beginning in January 1, 2014, to assist in covering the cost of the Medicaid expansion. However, the State's actual commitment to the Healthy Indiana Plan is limited by the amount of the State's Cigarette Tax revenues that the General Assembly has allocated to HIP. The current annual revenue has been approximately $125 million per year, rather than the $154 million illustrated by the CEA.

19. Exhibit 33 also illustrates a savings of $126 million per year through the Hospital Uncompensated Care for the Indigent (HCIP) program. However, CEA inadvet1ently illustrated the biennial budget amount for HCIP rather than the single year value. The actual annual savings for canceling HCIP in light of expanded Medicaid under PP ACA would be $63 million per year.

20. The CEA report also *under*estimates cost savings the State may realize from cancelling its high-risk pool ICHIA program. The CEA estimates that the State currently spends about $15 million annually on that program, but annual outlays are closer to approximately $40 million per year.

21. By combining the annual savings figures noted in paragraphs 18, 19 and 20 ($125M + $63M + 40M), the savings would be re-stated at approximately $228 million per year from these three sources rather than the $296 million estimated by CEA on page 38, Table 3 of Exhibit 33.

22. The differences between our estimates for Indiana and CEA's estimates are illustrated in the following table:

	Milliman/ Indiana	CEA, Exhibit 33 at Table 3
Medicaid Expansion	$(320)M	$(62)M
Healthy Indiana Plan	$125M	$155M
ICHIA	$40M	$15M
Tax Credit	$12M	$12M
HCIP	$63M	$126M

Hidden Tax	$30M	$30M
Net Impact	$(50)M	$275M

Note: Values have been rounded to millions.

23. There are further qualifications of these amounts. HCIP, for example, is not a stand-alone state program, but is instead part of Indiana's Medicaid Plan. Accordingly, Indiana will actually continue to incur the full cost of HCIP even as it assumes greater costs for expanded Medicaid coverage under PPACA. So, reducing that savings line item to zero, Indiana's Medicaid exposure will actually be near $113 million.

24. It is also important to observe that, while Medicaid expansion costs are in today's dollars which will inflate over time, the State's revenue stream currently dedicated for funding HIP and HCIP, the Indiana Cigarette Tax, will not. In fact, since Indiana's Cigarette Tax increased to 44 cents per pack and an additional federal cigarette tax has been implemented, Cigarette Tax revenue has decreased as more and more smokers quit smoking. That revenue stream is, thus, highly unlikely to keep pace with inflation, meaning that Indiana will have to find other revenue sources to pay its share of the expanded Medicaid program that is mandated by PPACA, not by its own program decisions.

25. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 18th day of November, 2010.

_____

Robert M. Damler, MAAA,
Principal and Consulting Actuary,
Milliman, Inc.,
111 Monument Circle, Suite 601,
Indianapolis, Indiana 46204

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/23/10
DOCUMENT NO.: 135-1

FURTHER DECLARATION OF ELIZABETH DUDEK

Pursuant to 28 U.S.C. § 1746, I, Elizabeth Dudek, declare the following:

1. My name is Elizabeth Dudek. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Florida Agency for Health Care Administration (AHCA) as the Interim Secretary.

2. I have served as Interim Secretary since September 2010.

3. As the Interim Secretary, I am the highest ranking official in AHCA and am responsible for

all activities of the Agency including the operation of the Medicaid program.

4. The facts and statements in this further declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. I previously provided a declaration in this matter describing the projected impacts of the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA) on the Florida Medicaid program. As I stated in that declaration, AHCA projects that PPACA will cost the Florida Medicaid program $142,460,765.00 in state general revenue in Florida's 2013-2014 fiscal year. This amount increases going forward, and by 2018-19 the projected costs to Florida are estimated to be just over a billion dollars per year, or $1,012,206,268.00, in general revenue.

6. I have since reviewed the Defendants' claim that PPACA will save the State of Florida $377 million per year, which appears to be based on a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report).

7. The CEA report, however, does not appear to address the impact of the final version of PPACA on the state government of Florida. In fact, at the time the CEA Report was issued in September 2009, PPACA was not yet in its final form. Thus, it appears that the CEA Report only attempted to address possible impacts of PPACA, while guessing at what the national

health care reform effort would look like when it was completed.

8. The Defendants' appear to draw their $377 million savings figure from a column of a chart on page 26 of the Report (the exact figure in the column is $377.2 million). Two assumptions made with respect to this $377 million amount did not come to pass, however, in PPACA's final version. First, the $377 million figure assumes 100% federal financing of Medicaid expansion (CEA Report p. 26). PPACA itself only ultimately provides for 90% federal financing. The state governments, including Florida's, will supply the other 10%. The $377 million figure in the Report thus underestimates the costs to the state government of Florida from Medicaid expansion. Second, the CEA Report appears to assume that, if the national health care reform effort were to be successful, all uncompensated care would disappear. This also did not come to pass in PPACA's final form.

9. Using the CEA Report to forecast savings to the State of Florida also presents other issues. For example, the CEA Report analyzes possible savings to be realized by state *and local* governments taken together. All or virtually all of the $377 million in projected savings described in the report would accrue to local governmental entities such as Miami-Dade County, Hillsborough County, and Duval County. As AHCA Interim Secretary, I have no knowledge regarding any alleged or projected costs or savings to these local governments, and thus cannot testify as to whether the localities

described will realize any net savings from PPACA.

10. The CEA Report, however, appears to project that all uncompensated care in Florida would disappear (which did not actually occur in PPACA's final form), and that local governments will save as a result. CEA Report at p. 24, 26. Uncompensated care is not likely to disappear as a result of PPACA. To the extent uncompensated care diminishes as a result of PPACA, local government savings from its disappearance generally will not result in any savings to the state government's budget. In fact, a reduction in uncompensated care may be at least partially the result of previously uninsured persons enrolling in Medicaid. In other words, any savings realized by local governments from a reduction in uncompensated care might actually increase costs for Florida Medicaid.

11. Finally, the CEA Report forecasts that additional savings ($117 million) "may come" from the Children's Health Insurance Program. (CEA Report at 24-25) My prior declaration included AHCA projections that incorporated the State of Florida's potential for savings related to CHIP (*see* ¶ 20), such that this figure does not discount the annual estimated cost to the State of Florida to which I previously attested (*see* ¶ 5, above).

12. As a result of the factors described above, AHCA stands by the projections contained in my

previous declaration, and will not alter its projections based on the CEA Report.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 18, 2010, in Tallahassee, Florida.

_____

Elizabeth Dudek
Interim Secretary
Agency for Health Care Administration

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/23/10
DOCUMENT NO.: 135-1

FURTHER DECLARATION OF J. ERIC PRIDGEON

Pursuant to 28 U.S.C. § 1746, I, J. Eric Pridgeon, declare the following:

1. My name is J. Eric Pridgeon. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Florida House of Representatives as the Budget Chief for Health Care Appropriations.

2. I have served as Budget Chief since 2008. I have 15 years of experience working on Medicaid budget and policy matters at the state level.

3. As the Budget Chief, I write the annual budget for the Florida Medicaid program. In addition, I serve as a principal for the Social Services Estimating Conference which projects enrollment and costs for the Medicaid program, and monitor Medicaid expenditures and analyze budget amendments throughout the fiscal year. Based on my employment, I am familiar with the Patient Protection and Affordable Care Act (PPACA) and the effects (actual and projected) of the PPACA on Florida's Medicaid program.

4. I am making this declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Florida is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. Earlier declarations were provided in this matter by Elizabeth Dudek, Interim Secretary, State of Florida, Agency for Health Care Administration, and by Joanne Leznoff, Staff Director of the Appropriations Committee, State of Florida, House of Representatives. Those declarations attested to the impact of the Medicaid program provided in the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA).

6. I have since reviewed the Defendants' Memorandum in Support of their Motion for Summary Judgment and their claim that the PPACA will save Florida's state and local

governments $377 million per year, which is based on a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report).

7. Defendants cite several local government programs to arrive at this savings estimate.

8. To the extent that local governments seek to reduce some of the cited expenditures, they could only do so at a cost to the State of Florida.

9. Hillsborough County and Miami-Dade County both participate in funding the Medicaid program along with 20 other local governments that collectively provide over $584 million in intergovernmental transfers – funds that are used for the state Medicaid program.

10. The Hillsborough County and Miami-Dade County funding cited by the CEA Report are incorporated into the Medicaid program because these same sources (in whole or in part) are transferred to the State of Florida and used to draw federal Medicaid matching funds before being paid to hospitals within those counties in support of the local programs and providers described in the CEA Report.

11. Miami-Dade County and Hillsborough County contributed approximately $269 million of the intergovernmental transfers from local governments incorporated into the FY 2010-11 Medicaid budget.

12. Regardless of whether the specific local programs cited in the CEA Report remain intact following implementation of PPACA, the State

of Florida is dependent upon the contribution of local tax dollars to underwrite core costs of the Medicaid program including funding of specific or "exempt" payment rates to select hospitals (e.g. teaching hospitals, children's hospitals, and rural hospitals) and funding for specialty services such as trauma care and pediatric services.

13. The specific payment rates are known as "exempt" rates because these rates are not bound by statutory ceilings established by the Legislature as a way to manage Medicaid hospital expenditures within appropriations.

14. Loss of the local funding, should such a loss result from implementation of PPACA, would cost the State of Florida the equivalent of any "savings" to local government because the availability of essential services funded by intergovernmental transfers would be at risk if payments were reduced to non-exempt rates and funding for specialty services was eliminated.

15. The CEA Report upon which Defendants rely also assumes the elimination of uncompensated care in Florida ($102 million "Hidden Tax" estimate (CEA Report at 24)), which is contrary to the PPACA's own estimate of providing less than universal coverage (PPACA § 1501(a)). The CEA Report also bases this estimate on costs borne by both state *and local* governments, such that it is not accurate to attribute the full $102 million savings estimate to the State of Florida alone. The CEA Report does not set forth all the assumptions used to arrive at this number.

16. Defendants cite John Holahan & Stan Dorn, Urban Institute, *What Is the Impact of the [PPACA] on the States?* (June 2010) at 2 for the proposition that state and local governments would save approximately $70-80 billion over the 2014-19 period by shifting state-funded coverage into federally-matched Medicaid. The Holahan and Dorn report does not set forth all the assumptions used to arrive at this number. The Congressional Research Service (CRS) reports that varying impacts are projected for different states, with one state anticipating some savings, but no offsets are noted. (Six states anticipate more than $38 billion in increased costs.) Memorandum, *Variations in Analyses of PPACA's Fiscal Impact on States* (September 8, 2010).

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 22, 2010, in Tallahassee, Florida.

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J. Eric Pridgeon
Budget Chief, Health Care
Appropriations Committee
Florida House of Representatives

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/23/10
DOCUMENT NO.: 135-1

DECLARATION OF BRUCE R. RAMGE

Pursuant to 28 U.S.C. § 1746, I, Bruce R. Ramge, declare the following:

1. My name is Bruce R. Ramge. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Nebraska Department of Insurance (NDOI) as the Director.

2. I have served as Director of Insurance since November 15, 2010. Previously, I was Acting Director from November 1, 2010 through November 14, 2010. Prior to November 1, 2010, I

served in the capacity of Deputy Director and Chief of Market Regulation.

3. As the Director of Insurance, I am the highest ranking official at the NDOI and oversee all activities of the Agency including the regulatory oversight of the Comprehensive Health Insurance Pool (CHIP).

4. I am making this declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Nebraska is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. I reviewed the Defendants' claim that the PPACA will save the State of Nebraska approximately $27 million per year beginning in 2014 when the CHIP program ends with the individuals insured obtaining insurance through a proposed exchange. This is based on a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report, page 67).

6. The State of Nebraska does not subsidize premiums for the CHIP program. Under Nebraska law, the state is required to subsidize claims exceeding the amount collected in premiums from the CHIP members. In 2008, this amount was $27,375,209. In 2009, this amount was $24,051,163.

7. The provisions of PPACA currently anticipate the transfer of CHIP participants to Medicaid or health insurance products offered through a proposed exchange beginning January 1, 2014. A number of factors prevent me from predicting, at this time, the precise impact the transfer of CHIP participants to Medicaid will have on the State of Nebraska in 2014, including: claims in process, incurred but not reported claims, and the remaining administrative and wrap up costs. However, said transfer is not anticipated to be a cost savings for the State of Nebraska due to the additional burden of enrolling such individuals in the Medicaid system.

8. With the influx of CHIP policyholders who may purchase insurance through an exchange, the health insurance premium charged to all persons obtaining coverage through the exchange will necessarily increase to cover high claim individuals. Essentially, the experience of the high claim individuals will be reflected in the price of the premium for individual insurance coverage offered in Nebraska generally resulting in higher premium costs for all participating in an exchange. This results in a cost shift to all citizens of Nebraska purchasing through the exchange via an increase in premium costs.

9. Further, individual coverage in the exchange may become so costly that the CHIP policyholders will not be able to afford it even with a subsidy for which the CHIP policyholder may be eligible. An unknown number of current CHIP policyholders may also qualify for

Medicaid, resulting in an increase in costs incurred by the state.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 19, 2010, in Lincoln, Nebraska.

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Bruce R. Ramge
Director
Nebraska Department of Insurance